DOCUMENT RESUME

ED 188 981 SO 012 674

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TITLE An Analysis of U.S. Sex Education Programs and Evaluation Methods. Volume I.
INSTITUTION MATHTECH, Inc., Bethesda, Md.
SPONS AGENCY Center for Disease Control (DHEW/PHS), Atlanta, Ga.
REPORT NO CDC-2021-79-DK-FR
PUB DATE Jul 79
CONTRACT 200-78-0804
NOTE 168p.: For a listing of related documents, see SO 012 673.

EDRS PRICE MF01/PC07 Plus Postage.
DESCRIPTORS Adolescents: Educational Needs: Educational Objectives: *Educational Practices: Elementary Secondary Education: National Surveys: *Nonschool Educational Programs: Pregnancy: *Public Schools: *Sex Education: State Standards: Youth Programs

ABSTRACT

The volume, first in a series of five, presents an analysis of sex education programs in the United States. It is presented in six chapters. Chapter I provides a brief overview of sex education in the public schools and summarizes goals, forms, and prevalence of sex education. Chapter II reviews literature on the effects of school sex education programs based on behavior goals of sex education courses. Chapter III describes important features and outcomes of sex education programs and includes ratings by experts of the importance of these identified features and outcomes. Conclusions are that the dual goals of preventing pregnancy and improving the quality of relationships are mutually supportive: an emphasis should be placed on changing values, self-esteem, skills, and comfort in sex-related activities: and the classroom environment should be supportive and trusting. Chapter IV identifies 20 exemplary school sex education classes or programs and describes in detail the program at University City High School, St. Louis, Missouri. Chapter V provides an overview of nonschool sex education programs for teenagers. Programs analyzed include Planned Parenthood Affiliates, national youth organizations, local youth agencies, religious organizations, programs for pregnant teens, and hospital programs. Chapter VI contains analyses of state guidelines for sex education instruction in the public schools. Data for the study were obtained by completing a "Summary of Laws and Guidelines for Instruction in Sex Education" for each state. (Author/KC)

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ED188981

July 1979

Contract No. 200-78-0804

Report No. CDC-2021-79-DK-FR

AN ANALYSIS OF U.S. SEX EDUCATION PROGRAMS AND EVALUATION METHODS

Volume I

for the:

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Center for Disease Control
Bureau of Health Education
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SP 012 674

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ACKNOWLEDGMENTS

This project was a cooperative effort involving innumerable sex educators, administrators, researchers, and teenagers. The comprehensiveness of this report has been greatly enhanced by the willingness of these people to share their knowledge, materials, and data.

The efforts of several groups of people should be emphasized. The Research and Evaluation Group of the Bureau of Health Education of the Center for Disease Control identified the problem, supported the research, and provided guidance. Many teenagers completed different versions of different questionnaires, and shared with us their insights and personal feelings. Hundreds of sex education professionals either helped develop the list of important features and outcomes of programs or rated the items on the lists. Numerous teachers, directors, or administrators of both school and non-school programs carefully described their programs and answered many questions about their programs. In some cases they had to search carefully for materials to answer our questions. Every State Department of Education in the country discussed with us sex education in their respective states, and those states with guidelines or other materials sent us their materials.

In addition to these groups of people, a number of specific individuals proved particularly helpful. Martha Roper directed considerable effort to describing her class which is discussed in Chapter 4 of Volume 1. Her students laboriously completed drafts of the questionnaires which were twice as long as the final versions. Similarly, Mary Lee Tatum and Ann Fine reviewed the questionnaires and their students completed portions of drafts of the questionnaires. Michael Schaffer extensively reviewed curricular materials for sex education programs and provided the annotated bibliography of these materials in Volume IV. Joan Benesch and Barbara Barnum provided innumerable materials, suggestions, helpful comments, immediate answers to questions, and personal contacts; all of these were invaluable. Members of the Advisory Board gave us considerable direction and many helpful suggestions, especially at the beginning of the project. The Board included Barbara Barnum, Joan Benesch, Lois Brady, Michael Carrera, Paul Gebhard, Larry Green, Murray Kappelmen, Ron Magarick, Leslie McCary, and Joann DeLora Sandlin. At the Institute for Sex Research, Joann Huntington, Paul Gebhard, and their staff exhaustively reviewed all their materials for bibliographic references. Patricia Schiller suggested numerous important features and outcomes of programs. Finally, at MATHTECH, Walter Edward Cushen, Vice-President, provided a great amount of support, direction, and editorial expertise. Members of our support staff, Donna Bontecou, Roxanne Carter, Kay King and Carrie Scannell worked many long days typing and editing a camera-ready copy of all six volumes. Bernard Kirby also spent many hours carefully editing this report.

Last August we were saddened by the loss of Leslie McCary who made so many contributions to the field of sex education.

PREFACE

Introduction

This report reviews the literature on sex education programs, identifies the important features and outcomes of programs, selects and summarizes excellent school and non-school programs, reviews previous methods of evaluating programs, and develops new methods of evaluating programs. Hopefully this work will improve the teaching of sex education and the evaluation of that instruction. It should also facilitate the more rigorous evaluation of specific programs which shall be completed in a subsequent contract with the Center for Disease Control.

Organization of the Report

The complete final report contains an Executive Summary and five separate volumes. As is customary, the Executive Summary simply summarizes the major findings in the other volumes. Volume I is primarily substantive. It provides an overview of sex education, the empirical evidence in the literature of the effects of programs, important features and outcomes of programs, descriptions of exemplary school and non-school programs, and an analysis of state guidelines. Volume II focuses upon methods of evaluating programs. Specifically, it describes previously used methods of evaluating programs, specific suggestions for improving those methods, recommendations for new types of evaluations, and questionnaires which measure all the important features and outcomes of programs. Volume III is basically a questionnaire kit. It contains the questionnaires with directions for administering them and aids for scoring them. Volume IV is a large bibliography containing approximately 2,000 references to articles, books, reports, etc. on sex education. Finally, Volume V is an annotated bibliography of exemplary curriculum materials (both print and non-print).

Because each volume is designed to be independent of the others, there is necessarily some overlap between them. Specifically, the questionnaires appear in both Volume II, the methodological volume, and Volume III, the questionnaire kit. Similarly, the ratings of the features and outcomes appear in both Volume I-for they have major substantive implications, and in Volume II-for they have major implications for the design of the questionnaires.

Boundaries of This Report

Because this contract is one of the larger federal contracts in sex education, the public's understanding and expectations for this report may have become unrealistic. In particular, many people may incorrectly believe that this contract called for thorough and definitive evaluations of the best school and non-school sex education programs. Instead, this contract calls for the identification of exemplary programs and the development of methods

with which to evaluate these programs. The thorough evaluations will be conducted in a second contract.

Throughout this contract we defined sex education broadly. Thus, we examined both school and non-school programs, and even studied hot-lines and media events. In general, we included within our purview any program or activity primarily directed toward educating teens about sexuality. We excluded from consideration clinics or hospital programs which do not have significant education components, but which do distribute contraceptives and might thereby provide some information about contraceptives. In sum, we defined sex education as it is traditionally defined by sex education professionals.

One constraint in the contract involved the collection of new data. Had we been free to collect any new data needed, we would have more thoroughly tested the questionnaires. Specifically, we would have collected test-retest reliability data.

Finally, we should emphasize that sex education is a very rapidly changing field. Excellent programs are continually being created, and a few programs are ending because of limited funds or community opposition. Moreover, some of the best evaluations of programs are taking place as this is being written. This rapid change in the field coupled with the limited communication among sex educators and evaluators has undoubtedly caused us to omit some exemplary programs and evaluations. Despite these omissions, our major findings should be valid.

Reasons for Developing and Carefully Evaluating Sex Education Programs

To Determine the Effectiveness of Exemplary Programs in Reducing Sex Related Problems

In this country there are numerous sex related problems. Adolescent pregnancy is one of the most prominent. Several statistics clearly demonstrate this: approximately 1.3 million 10 - 19 year old girls become pregnant each year; about one-third of all girls become pregnant before they reach their twentieth birthday; the rate of illegitimate childbearing has increased by 75% among 14-17 year olds; teenagers give birth to one-fifth of all U.S. births; and more than two-thirds of these births are unintended.

Moreover, the consequences of these 1.3 million pregnancies are disastrous. The hundreds of thousands of teenagers who choose to terminate the pregnancies must deal with the emotional and physical consequences of abortion. For those teenagers who do not choose the alternative of abortion, there is a higher risk of miscarriage, of death during delivery, and of physical complications after delivery. In addition, there are the social and emotional consequences stemming from the disruption of education and employment, the higher risk of divorce, and the greater chance of welfare dependency. The children of these adolescents tend to suffer from poorer health and are more likely to be victims of child abuse. Clearly, higher teenage pregnancies are a national problem.

A second major sex related problem is venereal disease. In this country,

gonorrhea and syphilis rank first and third among all reportable communicable diseases. Moreover, of the estimated 10 million people who were infected by all forms of VD in 1978, 65% were young people between the ages of 15 and 24.

A third problem is rape. The majority of all rapes occur among young people and the majority of rapes among adolescents occur between acquaintances. This latter statistic is particularly important because education may more easily reduce acquaintance rape than other kinds of rape.

Finally, there are the innumerable sex related problems which are extremely important, but which lack reported frequencies. There is the lack of communication between parents and teenagers about sexual matters. There are the conflicting messages that teenagers receive from the media, peers, and some adults. There are the many cases of submitting to pressure from peers or potential sex partners with subsequent feelings of guilt or dissatisfaction. There are the many frustrations resulting from the inability to express feelings, to make decisions, and to facilitate healthy relationships. There are also the frustrations resulting from a lack of acceptable sexual outlets. Some of these problems produce specific sexual dysfunctions (e.g., impotence, lack of orgasms, and premature ejaculations). Others, more generally, prevent enjoyment of sex and produce an unhealthy sexuality. These problems often continue into adult married life and add considerable stress to marriage.

These sex related problems and others are important and evidence suggests that sex education programs may partially reduce them. If so, then it is important to know which programs are most successful, why those programs are successful, and more precisely, how successful are those programs.

To Determine the Effectiveness of Existing Programs

According to a recent report by the National Institute of Education 37% of the high schools throughout the country have a separate unit or class on sex education. Although this figure may be misleadingly high, a substantial effort is being devoted to some form of sex education instruction. However, very little effort is being devoted to a careful evaluation of that instruction. This void should be filled.

To Reduce Community Conflict and Conflicting Claims about Sex Education

During the last decade there have been many heated conflicts over sex education in many communities. In some cases teachers have been fired, and in other cases school board members and others have been removed from office primarily because of their views on sex education. During those conflicts, many competing claims have been made by the supporters and opponents of sex education. For example, the opposition has claimed that sex education will destroy morality, increase sexual activity, and thereby increase pregnancy as well. Supporters of sex education have claimed that greater knowledge, higher self-esteem, greater clarity of needs and values, and improved decision-making skills, communication skills, and assertiveness skills will reduce unwanted pregnancies and facilitate healthier relationships. If careful evaluations of programs are completed, then some of these conflicts can be resolved.

Chapter 1:
A Brief Overview of School Sex Education in the U.S.

Introduction

This chapter provides a brief overview of sex education in American public schools. Thus, it is directed toward those readers who have relatively little familiarity with sex education. It summarizes some of the goals of sex education, the various forms of school sex education, and the prevalence of that instruction. In contrast, the following chapter provides a more detailed review of the effects of sex education, and all subsequent chapters present new information about school and non-school sex education and methods of evaluating it. Thus, readers who are more familiar with sex education may wish to skim this chapter and read more carefully subsequent chapters.

Goals

The goals of sex education are both numerous and varied. A sampling of them follows:

--to provide accurate information about sexuality
--to facilitate insights into personal sexual behavior
--to reduce fears and anxieties about personal sexual developments and feelings
--to help people make more informed choices
--to encourage more responsible and successful decision-making
--to develop skills for the management of sexual problems
--to encourage students to question, explore, and assess their sexual attitudes
--to develop more tolerant attitudes toward the sexual behavior of others
--to facilitate communication about sexuality with parents and others
--to facilitate rewarding sexual expression
--to integrate sex into a balanced and purposeful pattern of living
--to create satisfying interpersonal relationships
--to reduce sex related problems such as venereal disease and unwanted pregnancies.

Most sex educators would agree with most of these goals. However, a few sex educators would differ with a few of these goals and would add a few of their own. In particular, they would stress that a particular value system should be encouraged (e.g., that heterosexual activity within marriage is the only moral or acceptable type of sexual activity).

The goals specified above have two common qualities that should be emphasized. First, they are broadly humanistic. Second, they include much more than increases in knowledge. Rather, they focus upon changes in values,

attitudes, skills, and behavior. Thus, these goals are far more ambitious than those of most other courses.

Sex Education in U.S. Schools

Elementary School

Sex education begins with the child's first years in school. In many elementary schools, this instruction is informal and unplanned. The children learn from the role model provided by the teacher and from the manner in which common sexual incidents are treated (e.g., a boy looking at a girl's underpants, one child kissing another, one child staring at another child of the same sex going to the bathroom, or some child using a "dirty word"). In some classrooms, these incidents evoke discussions of sexual matters and the children learn directly from those discussions. In other classrooms, these incidents are treated as problems and discussions are quickly shifted to other topics. In these cases, the children learn that certain sexual topics are not to be discussed and that certain sexual activities are "naughty". In either case, these incidents and the manner in which they are treated help shape subsequent attitudes and behavior.

In addition to these spontaneous activities, many elementary schools plan activities with the following objectives in mind:

--to develop an awareness of the child's self and a strong self-concept
--to increase the awareness of personal feelings and methods of expressing and managing them
--to facilitate the growth of responsibility for individual behavior
--to develop basic social skills which help solve conflicts and facilitate friendships
--to increase the understanding of family and sex roles
--to increase the knowledge of life cycles and reproduction in animals.

These objectives are clearly part of any good elementary education, and are typically not considered sex education. Nevertheless, they help form the basis for a subsequent healthy sexuality.

Many schools include a brief unit on menstruation for girls. Although menstruation is typically described as a normal body function, few schools take the opportunity to discuss other normal sexual responses.

A few schools considered exemplary by sex educators focus more directly upon other sexual topics. They incorporate activities into the classroom which strive for the following:

--to strengthen the students' acceptance of their bodies and their sexual feelings
--to help them understand various topics such as the vocabulary for body parts, body functions, changes during puberty, sexual intercourse, pregnancy, child-rearing, and the emotional aspects of sexuality
--to help them understand and clarify their personal views on different sexual ideas and values
--to enable the students to discuss sexuality comfortably and intelligently.

Although activities and curricula have been designed for these objectives, few elementary schools actually use these materials or discuss sexuality so openly, and few have planned units of instruction. According to Gnaltas (1978), sex education with formalized curriculum is practically non-existent in elementary schools. Sex education is typically incorporated into other topics, if it is covered at all. This has important implications both for the depth of the coverage and the training of the teachers. Commonly elementary school teachers have little special training in sex education.

Elementary school sex education has rarely been studied and few specific programs have been evaluated. This is partly because sexuality is incorporated into other units and is treated differently by different teachers. It is also because the vast majority of elementary school students are not engaging in sexual intercourse and are not becoming pregnant. Thus, the need for careful evaluations has not been recognized. However, the bulk of elementary school instruction is directed toward developing attitudes and skills clearly needed in adult life. This suggests that sex education in elementary school should be better developed and better evaluated.

Junior High School

In junior high school, the students are more directly encountering the physiological, emotional, and social consequences of puberty and adolescence. Obviously, they are more aware of their bodies and their emotional and sexual feelings toward the opposite sex.

In a few schools, teachers focus upon some of these changes, feelings, and problems. They discuss the differences in physical growth patterns, the changes that take place during puberty and adolescence, some of the details of reproduction, flirtation, necking, masturbation, venereal disease, responsibilities in interpersonal relationships, and values clarification. Of those schools which do include these topics, the majority cover them in other courses or units (e.g. biology, health, or physical education).

Although the literature is sparse, it appears that most junior high schools do not cover most of these topics, expecially the more sexual topics such as masturbation.

Senior High School

Educators have devoted much greater effort to developing sex education for high school students. Moreover, these educators represent a grass roots movement. That is, many different teachers or communities have developed their own materials and courses relatively independently.

Partly because of this independent development, high school sex education programs have an enormous diversity. They vary on a number of important dimensions:

Duration of Instruction Some programs last for only a single day or for only a few periods on successive days; others last for an entire year.

Number of Sessions A number of programs continue for a single full day, while most are divided into separate periods on different days.

Separate vs Integrated In many schools, instruction is divided among many different classes and students are encouraged to take all of them. Actually, in these programs, most students receive part of the instruction in one course, but fail to take the other courses. In other schools, sex education is a separate elective unit or course for which parental notification or permission is frequently required.

Topics Covered Some courses cover only the bare essentials (e.g., anatomy, reproduction, and venereal disease). Other courses are far more comprehensive and cover such topics as variations in growth patterns; emotional and social aspects of dating, necking, petting, and sexual intercourse; sexuality as part of our total personality; advantages and disadvantages of premarital sexual activity; the probability of becoming pregnant; masturbation; homosexuality; rape; responsibilities of parenting; the characteristics of different types of contraception; the methods for obtaining contraception; values clarification; and decision-making, communication, and assertiveness skills.

Classroom Atmosphere In some programs, the teacher or other professionals simply lecture to the students. In other better and more comprehensive programs teachers develop a classroom atmosphere with trust, concern, and empathy. In these supportive atmospheres, students raise many questions and issues, and express both feelings and concerns. In some classrooms, particularly in parochial schools, sexuality is discussed within the context of religious values. In public schools, values and responsibility are stressed, but particular values are not emphasized, and the atmosphere is less judgmental.

Modal Types

Many of these dimensions are related to one another and produce three especially common combinations of traits or modal programs. The first is a "one shot" program in which teachers or outsiders present information on reproduction and possibly contraception during one or two class periods of approximately fifty minutes each. Although questions can be asked, most of the time the speaker lectures to the students.

The second modal type continues for one to two weeks. Typically it is part of another course (e.g., health) and it includes lectures, a few discussions, and a few films on several topics such as reproduction, venereal disease, and possibly contraception.

Finally, the third modal type is a more comprehensive sex education class. It may last an entire semester and is devoted to a wide variety of sexual matters. Thus, it typically contains cognitive, affective, and skill components. That is, factual material is presented; attitudes are shared and discussed; and decision-making and communication skills are developed. Many of the topics mentioned above are covered at least once. Although teachers provide lecture material, the emphasis is upon class discussions and the sharing of experiences and feelings. Commonly there is an effort to develop a supportive and non-judgmental atmosphere.

Program Innovations or Variations

Although there are innumerable exciting innovations in sex education, there are five that are particularly important.

Peer Counseling

The immediate goal of peer counseling programs is to train students both to provide accurate information and referral services to their peers and to listen with sensitivity and respect to problems of other students. Training for the counselors usually lasts twelve to sixteen weeks, with several hours per week devoted to didactic training, role-playing, and small group discussions. After the training, the peer counselors maintain a "Rap Room" with the help of a faculty advisor. In this room the students have access to literature and films on sexuality. In addition, it is a place where discussions on sexual matters are frequently held.

Parental Involvement

Some of the most successful programs emphasize parental involvement both in the initial planning of the program and in the continued development of the program. Often this involvement is most helpful when it is formalized in a committee which includes parents, other community members and school personnel. The parents provide input from the community, raise questions of concern, and provide a buffer to opposition.

Programs for Parents

A few schools throughout the country have developed programs for parents of teenagers that complement the programs for the students. These are designed 1) to give the parents more accurate information about sexuality today, 2) to provide parents with information about the topics being covered in the students' classes, and 3) to improve communication between the teenagers and their parents. The success of these programs is not yet known, because few of them have been carefully described or evaluated.

Two Day Marathons

Intensive marathons which have been widely used in adult therapy or encounter groups have been rarely used in sex education. However Rosenberg and Rosenberg (1976) have described one provocative session in a private school. Senior year students and their parents participated in a two-day marathon patterned after the Sexual Attitude Reassessment widely used in the training of sex educators. Six sessions held during two days were interspersed with one to two hour group discussions with fewer than ten people each. The first session was devoted to a variety of sexual topics. Its basic purpose was to establish trust among the participants. The second session dealt with homosexuality; the third contained a "saturation" of sexually explicit films; the fourth was devoted to viewing and discussing films on interpersonal relationships; the fifth focused upon male and female role issues; and the sixth emphasized morals and values. One of the major outcomes of the program was the increased communication between the students and their

parents. This is particularly important because other studies have suggested that improved communication with parents may delay sexual intercourse and reduce unplanned pregnancy. However, the explicit films are certainly too controversial for many communities.

Provision of Contraceptives

Several years ago there was only one school in the country, Woodson High School in Washington, D.C., which provided contraceptives to the students in the high school itself. However, a few other schools have now included the provision of contraceptives within their program.

There are of course several advantages to providing contraceptives in the school health clinic. It reduces the fear and inconvenience of going to a strange clinic in another part of town. It enables sexually active students to quickly obtain contraception. It also provides a link between the sex education instruction on contraception and the contraception itself.

Although numerous students used the clinic at Woodson, the number was less than might have been expected. One reason was the lack of anonymity; when students went to the clinic, their friends sometimes saw them. At Woodson and the other high schools now offering contraception, the program is being restructured to overcome this problem.

Prevalence of High School Sex Education

The different studies on the number of students receiving sex education and on the number of schools offering sex education provide somewhat conflicting estimates. In 1974 the National Education Association (NEA) sampled 800 public school systems and found that only ten percent "fully provided" sex education (NEA 1974). In 1978 the National Institute of Education (NIE) took a random sample of U.S. public high schools and found that 36% offered a "separate course" in sex education (NIE 1978). This estimate appears unreasonably high and subsequent analysis suggests that many respondents considered a "separate course" any unit on sex education within any semester's course. In a third national survey of over 500 school superintendents, Hottois and Milner (1975) report that over half had some kind of sex education program. This estimate is probably high because districts with sex education were apparently more likely to return the questionnaires.

Moreover, the percentage of schools offering sex education is less than the percentage of school districts offering sex education, and similarly, the percentage of students receiving sex education is less than the percentage of schools offering such instruction. Thus, the estimates above of the number of schools and school districts offering sex education need to be reduced in order to estimate the percentage of students receiving instruction.

Prior to 1979, Maryland was the only state to mandate sex education in high school (See Chapter 6 of this volume). Moreover, this mandate has existed for six years. Nevertheless, many high schools in Maryland still do not offer any courses in sex education, and in several sampled schools with sex education courses, less than a fourth of the students take the courses.

If one accepts the NIE estimate that 36% of all schools offer sex education, and if one estimates that approximately one-fourth of all students in each high school with sex education actually take sex education, then less than ten percent of all students actually receive sex education. Moreover, if fewer than 36% of all schools offer a separate course, or if fewer than one-fourth of the students take such a course where it is offered, then far fewer than ten percent of all teenagers receive a separate course in sex education.

Fewer studies have examined the structure of courses. However, the NEA (1974) study reported that sex education is most frequently a brief unit within another course. Similarly, Huether and Gustavus (1977) report that the majority of the units last less than ten hours. In a survey of school districts Hottois and Milner (1975) found that about two-thirds of them discuss human reproduction, adolescent changes, and venereal disease, that slightly more than half cover ethical standards and masturbation, and that less than forty percent cover contraception. Once again, it should be realized that the percentage of schools covering these topics is less than the percentage of school districts and that the percentage of teenagers receiving instruction in these areas is still less.

Several national surveys of individuals provide a different type of evidence for the prevalence of sex education. In 1970 Abelson, et al. conducted a national probability sample of several thousand adults (over 20) and young people (between 15 and 20). Less than 10% of the adults said schools were a source of information, but 38% of the young people indicated school was a source. This suggests that either adults forget their earlier sources or sex education is increasing. Winograd (1978) reported the same trend in a three generation sample of several hundred women.

In 1973 Sorensen studied over 400 teenagers in a national sample. Although he attempted to obtain a random sample, there are questions about the generalizability of the data, and his respondents may have been more knowledgeable about sex and more sexually active than the population at large. Within his sample nearly 40% had never read a serious article about sex and more than 50% had never read an educational book about sex. This suggests that at least this number had not been part of a comprehensive sex education program.

In 1974 Spanier analyzed data from an excellent random sample of 1177 white college students. Only 18 percent of the males and 23 percent of the females had attended a sex education course in either junior or senior high school.

Finally, Zelnik and Kanter (1977) studied an excellent sample of 1800 never-married women between the ages of 15 and 19. About two-thirds of the whites had received instruction on menstruation in school, and about three-fourths of the blacks had received such instruction. More surprisingly, about half the women indicated they had received information about contraception. However, the depth of the coverage was not examined.

In sum, these studies suggest that sex education may be increasing in schools, that large numbers of students receive a minimal amount of

instruction on menstruation and reproductive anatomy, and that a small percentage of students receive comprehensive instruction.

Political Context of Sex Education

Both sexual behavior and sex education are extremely controversial topics in this country. Consequently, both the existence and the nature of sex education are continually questioned in many communities. In general there are many educators and other professionals working with teenagers who support comprehensive programs. They believe that sex education should incorporate discussions of sexual intercourse, contraception, and values clarification. In contrast, there are many citizens responding to the increased sexual behavior of teenagers who believe that sex education should be taught only in the home or only within a religious context. Thus, these citizens frequently oppose sex education in the schools.

Despite the many newspaper headlines on sex education battles and despite the termination of a few sex education programs, most Americans apparently support sex education. Several studies support this claim. First, when parents are given the option of preventing their children from participating in a sex education class, only 3% choose to do so. Second, in 1974 the National Opinion Research Center of the University of Chicago interviewed a random sample of 1484 adult Americans. About 78% favored both sex education in schools and the provision of birth control information to teenagers who want it. Third, a 1977 Gallup poll indicated that 70% of Americans believe that contraception should be taught in school, nearly double the proportion holding that belief in 1970. Fourth, a 1975 national study of school superintendents reported that only 5% of existing programs were eliminated following controversy, but that more than 50% were expanded following controversy (Holtois and Milner, 1975).

Numerous studies of specific cities or communities provide the same results. For example, in a widely respected study, the Project for Human Sexual Development interviewed 1400 people in Cleveland, Ohio. They found that 80% of the parents support sex education in school and more than a majority believe that contraceptive information should be made available to preteenagers. Similarly, Levin et al. (1972) surveyed 277 randomly selected citizens of a midwest city. They found that 88% of the respondents agreed that "sex education should be offerred in schools", 85% would allow their own children to take a course, and only 6% believed school sex education was an invasion of family rights and privacy.

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Chapter 2:
The Effects of School Sex Education Programs: A Review of the Literature

Introduction

Advocates of sex education courses have established for themselves a truly formidable task. They have described many goals for sex education programs including changes in the students' knowledge, attitudes about sexual matters, self perceptions, decision-making skills, communication skills, other interpersonal skills, fears, and social and sexual behaviors. In some cases changes in the frequency of particular types of behavior are sought. In other cases, changes in the quality of behavior are sought. For example, it is hoped that sex education will facilitate rewarding sexual expression, tolerant behavior, successful decision-making, and satisfying interpersonal relationships. These goals are extremely demanding, and in many respects, it is unfair to judge sex education programs by the degree to which they meet all of these goals.

The ambitiousness of these goals can be demonstrated by comparing them to the goals of other courses. In many classes, the goals include the increase in knowledge of particular topics (e.g., American history) or the improvement in specific academic skills (e.g., reading or math). Rarely do the goals of other courses include changes in attitudes, interpersonal skills, or nonacademic behavior. For example, civics classes are not evaluated according to their ability to make better citizens out of the students even though this may be an implied goal. Similarly, English classes are not evaluated according to their ability to change the reading and speaking habits of students during their free time.

For two primary reasons, it is especially difficult for sex education classes to change the sexual behaviors of the students. First, the students receive an enormous amount of other information or misinformation about sexuality from their peers, their parents, television, magazines, and other sources, and much of this information is conflicting. Second, the sexual behaviors of the students are also strongly influenced by the emotional and sexual needs of the teenagers.

Because these difficult goals have been proffered for sex education, the extent to which sex education programs meet them shall be examined. However, for the reasons presented above, sex education programs should not be unduly criticized if they do not meet these difficult goals.

This review of the literature is based upon the bibliography presented in Volume IV. The procedures used to compile that bibliography are described in the introduction to that volume. They included a thorough search of all the materials at the Institute for Sex Research, a review of other bibliographies, and numerous computer searches. Despite the care with which that bibliography was created, it undoubtedly omits some relevant studies. Nevertheless, the

bibliography should be reasonably complete, and the conclusions based upon those studies are not likely to be changed by the omitted studies.

Methods Employed in the Empirical Studies

By far the most common method of analyzing the effects of sex education programs utilizes the experimental design. The sex education class is considered the experimental group and some other class or group of students is considered the control group. Appropriately, the "treatment" consists of all the activites of the sex education class. Typically, pretests are administered during the first few days of class and posttests are given during the last few days of class. Of the numerous studies examined for this review, the vast majority employed such a design.

The studies using this design have two major strengths. First, by comparing the change in scores of the control group and the experimental group, various types of errors can be eliminated or controlled. For example, if a control group were not used, then it would be difficult, if not impossible to determine whether the changes that occurred in the experimental group were produced by the course or by natural maturation processes. Second, an experimental design can be used naturally in the classroom setting. That is, when students take a pretest, complete the course, and then take the posttest, this resembles their normal routine and appears natural. This is in contrast to some laboratory experiments which test psychological principles, but which also appear artificial to the participants.

However, these experimental studies contain several weaknesses which limit the validity of their conclusions. First, most of the studies evaluate single programs which have not been randomly selected. Thus, it may be inappropriate to generalize to other sex education programs. For example, some courses may be successful because of unusually charismatic teachers. Second, in most of the studies, evaluators are rarely able to randomly assign students to the experimental and control groups. This problem is accentuated by the fact that students who take sex education classes are probably different from those who do not. Because of other curriculum requirements, college oriented students may be less likely to take sex education classes. Sex education students may also have different values and behaviors and may be more or less receptive to changing their attitudes and behaviors. Third, very few of the studies measure the long-term effects of the course. Although some effects of the course may not become apparent until the students engage in sexual activity months or years later, other effects may become attenuated by the passage of time. Fourth, the questionnaires or measuring instruments are typically poorly designed. On the one hand, they exclude questions about some of the most important outcomes of programs. On the other hand, they often measure poorly those outcomes which they attempt to measure. For example, few of them are carefully pretested, and few report reliability and validity coefficients. Finally, many of the studies report the statistical significance of the findings, but few of them provide good indicators for the magnitude of the change. For example, the mean score of a class on some outcome may increase from 7.8 to 8.1 and this may be statistically significant, but the importance of that change cannot be determined from the report.

In several local and national surveys of teenagers (c.f. Zelnik and Kantner; 1977), scholars have measured both the respondents' participation in sex education programs and their sexual activities. Thus, by simply correlating these variables, these scholars could ideally measure the impact of sex education programs. Unfortunately, these studies cannot usefully serve this purpose for one major reason. They consistently fail to ask questions about the quality of the sex education program (e.g., its length, the topics covered, the enthusiasm, knowledge, and openness of the teacher, and the use of group discussions and role-playing). Although these surveys are most useful for other purposes, they have relatively little value in estimating the impact of sex education programs. Thus, few of them are discussed in this chapter.

All of these strengths and weaknesses are far more thoroughly discussed in Volume II. Moreover, that volume provides solutions to some of these problems.

Results of These Studies

In the sections below, the results of the studies are summarized. These results are divided into the effects upon knowledge, attitudes, and behavior.

Effects upon Knowledge

Although schools are criticized for not teaching students enough or for not teaching particular skills, in general schools have demonstrated their ability to effectively increase the knowledge of most students. Thus, one would expect that sex education classes, like other classes, would improve the knowledge of the participants. This supposition is supported by the empirical literature.

Innumerable studies measure the impact of sex education courses upon the knowledge of the students and their findings are nearly unanimous--instruction in sex education does increase knowledge of sexuality (c.f. Angrist, Mickelsen, and Penna, 1976; Bardis, 1963; Bernard, 1973; Coates, 1970; Crosby, 1971; Davidow, 1976; Finkel and Finkel, 1975; Garrard, et al., 1976; Herald et al., 1973; Hoch, 1971; Kolesnik, 1970; Lamberti, 1977; Marcotte and Kilpatrick, 1974; Marcotte et al., 1976; Mims et al., 1974; Mims et al., 1976; Parcel and Luttman, 1979; Perkins, 1959; Shipley, 1974; Vennewitz, 1975; Vorgeas, 1973; Watts, 1974; and Wilson, 1974). Some of these studies are based upon college students, but their findings are nevertheless relevant and they are consistent with those of the high school studies.

Significantly, only two studies, Spanier (1976) and Weichmann and Ellis (1969), found no impact of sex education upon subsequent knowledge and these two studies had serious methodological weaknesses. Both of them were surveys of college students and they simply correlated present knowledge with previous participation in a sex education course. They did not measure any of the characteristics of the course and some respondents may have included within

the definition of sex education a brief unit on VD or menstruation.

All the remaining studies indicate that sex education courses do increase the students' knowledge. Most of them employed an experimental design similar to that described above. An exception was the study by Finkel and Finkel (1975). This study is important because it uses a somewhat different methodology and confirms the experimental studies. Finkel and Finkel surveyed 421 male students in a northeast urban high school. Those students who had taken a mandatory hygiene course performed better on a six item knowledge test than students who had not taken the course. Because some of the students had undoubtedly taken the course months or possibly years prior to the test, this study suggests that their knowledge may not have been completely attenuated by time. Unfortunately, the authors failed to control year in school or age, and thus they failed to disprove an alternative hypothesis that the students who had not taken the course were simply younger and hence less knowledgeable.

These studies describe many different programs with different structures (e.g., one week units, semester courses, lectures, and rap sessions). According to the literature, nearly all of these courses are successful. Ideally, the literature would demonstrate which course structures or characteristics are most effective. Unfortunately, one cannot make these types of comparisons, because the studies are not comparable. They use different knowledge tests, examine different populations of teenagers or adults, etc. However, one study (Watts, 1974) compared the efficacy of three different course formats: five hours of lecture; five hours of small group discussions and individual studies; and five hours of audio-visual material. In each of the three methods or classes, there were approximately twenty college students. All three methods of instruction produced statistically significant increases in knowledge, and the differences among the three increases were not statistically significant. This suggests that all the methods were aproximately equally effective. However, the lecture method was slightly more effective than the other two methods in increasing knowledge and changing attitudes.

All of these studies also indicate that courses can effectively teach any topic which is carefully covered in the course. In other words, if sexual material is taught properly, there is nothing exceptional about sexual material that prohibits students from learning it.

This demonstrated success of sex education programs to increase students' knowledge in many diverse areas of human sexuality should be emphasized and applauded. In general our society approves of greater knowledge and assumes that greater knowledge facilitates more responsible decision making. Moreover, numerous studies (c.f. Driscoll and Davis, 1971; Goldsmith, et al., 1972; Presser, 1974; Shah, et al., 1975; Sorensen, 1973; and Zelnik and Kantner, 1972) all indicate that teenagers are very ignorant about reproduction and contraception. Moreover, studies (e.g. Sorensen, 1973; and Zelnik and Kantner, 1972) have all demonstrated that one major reason that teenagers do not use contraception is because they incorrectly believe they cannot or will not become pregnant. Greater knowledge should help dispel some of these myths. On the other hand, it should also be recognized that greater knowledge will not necessarily cause teenagers to make better decisions, and the actual behavioral impact of programs should be studied.

Effects Upon Attitudes

Numerous studies have examined the effects of sex education courses upon the students' attitudes (c.f. Bernard, 1973; Bidgood, 1973; Carton and Carton, 1971; Crosby, 1971; Davidow, 1976; Diprizio, 1974; Garrard, et al., 1976; Gunderson, 1976; Hoch, 1971; Lamberti, 1977; Lance, 1975; Marcotte, 1976; Mims et al., 1976; Olson and Gravatt, 1968; Parcel and Luttman, 1979; Rees and Zimmerman, 1974; Steinman and Jurich, 1975; Yarber, 1978; and Zuckerman, et al., 1976). However, with only a few exceptions, these studies examine college courses and college students.

One of the best studies of junior or senior high school programs is the study conducted by Parcel and Luttman at the University of Texas Medical Branch. The course was a voluntary course offered after school to all eighth graders. It was taught by volunteer teachers and by medical school staff. Thus, the course was not a typical sex education class. However, the structure included eight one and one half hour presentations and discussion groups and is more typical. It should be mentioned parenthetically that the course is in the process of being developed and will be integrated into the regular eighth grade curriculum during the fall 1979 semester.

Approximately one hundred students completed pre and post questionnaires. About twenty percent of these students attended only a few sessions in the course and about another twenty percent attended less than half. Thus, they could serve as convenient control groups. However, it should be realized that the experimental and control students undoubtedly differ in many respects. The authors devoted considerable attention to developing and evaluating the questionnaires, and they report reasonably high reliability coefficients.

None of the groups experienced a signficant change in their levels of guilt or worry about sexuality. Moreover, there was no overall trend toward greater permissiveness as a result of the course. However, in the experimental group there was a fifty percent decrease in the feeling that masturbation in general is wrong, and an increase in the belief that masturbation was acceptable for oneself. This outcome was one of the goals of the course. The experimental group also developed a greater acceptance of homosexuality for others, while maintaining their previous feelings about homosexuality for themselves. Finally, the students in the experimental group became more comfortable with the idea of their future marriage partners having had sexual experience.

Another excellent high school experiment was conducted by Hoch (1971). Sex education was covered for ten fifty-minute periods in a high school biology class. According to the author, the discussions were frank and non-judgemental. Hoch conducted both pre and posttests and used another class in the school as a control group. Not only did the students' knowledge increase, but on questionnaire scales, the students demonstrated a significant increase 1) in their acceptance of family planning and contraception, 2) in their acceptance of others' homosexuality, and 3) in their confidence in making later sexual decisions. In contrast, there was no significant change in their values for their personal behavior.

Samson (1977) examined the impact of sex education upon value and moral judgements. The course included thirty hours of lectures and discussions spread over eight months. Frequently it focused upon moral dilemmas. To measure the students' ability to make moral decisions, Samson and others interviewed each student for an hour and gave each student five dilemmas to solve. The student's solutions were then assessed using Kohlberg's stages of moral development as the criterion. In an experimental design Samson demonstrated that on sexual dilemmas, there was a 17% increase in the level of the experimental students, but only a 11% increase in the control students. On nonsexual dilemmas, both groups of students changed equally.

Crosby (1971) studied a semester's course in family life in rural Indiana. Using an experimental design and a fifty item self-esteem test, he found that the self-esteem of the experimental students did significantly increase, while it remained the same for the control subjects.

The remaining studies discussed below involve college students. Thus, the extent to which conclusions based upon college students can be transferred to junior high or high school students should be considered. There are several major differences between college students and high school students. College students are older and their attitudes are probably more clearly articulated and more stable than those of their younger counterparts. They are also further advanced in terms of psychological development and maturity. If this is true, then college sex education programs may have a smaller impact upon the developing attitudes of their students than high school classes. On the other hand, college students generally study harder and treat their courses more seriously than do high school students. This might give college courses an advantage. In sum, it seems likely that the effects of college classes may resemble those of high schools, but the magnitudes of change may differ.

For his Ph.D. dissertation, Harold Bernard (1973) carefully studied the effects of a college course containing twenty-four lectures, which were presented by specialists, and weekly discussion groups, which were led by trained students. Pre and posttests were given to four different groups in a four-group experimental design. During the course, students in the experimental group in comparison with students in the control group became more tolerant of homosexuality and masturbation. Other attitudinal changes were not unidirectional. Instead, they tended to converge toward a moderate position. Bernard states that "the changes discovered were moderate, well circumscribed, and in the areas specifically emphasized in the course" (p. 71).

Davidow (1976) for his dissertation also studied the effects of a college course. His findings indicate that the students in the course developed a greater tolerance toward masturbation and premarital sex for others. Significantly, he also measured these attitudes two months after the end of the course. By that time, the effects had diminished, but only slightly. However, this finding should not be weighed heavily, for the study is based upon only twenty-two students and there was no control group.

Garrard, Vaitkus, Held, and Chilgren (1976) analyzed the impact of a sexuality course upon 205 male medical students. The course included eighteen hours of didactic presentations and two days of discussions focusing upon

attitudes. Once again, there were no control subjects, but the authors retested the students six and twelve months later. In general the attitudes of the students became more liberal, and although the changes were attenuated somewhat during the following year, they nevertheless remained statistically significant. The actual amount of change was not great, however.

Rees and Zimmerman (1974) studied 230 college students who took a college course. At the end of the course, substantially greater percentages of the students felt that the following activities were normal: masturbation, oral sex, anal sex, sex during pregnancy, and homosexuality. Similarly, Zuckerman, Tushup, and Finner (1976) found that college students had more liberal attitudes after a course in sexuality than before.

Vennewitz (1975) studied the effect of a college course in human sexuality on the knowledge and attitudes of 167 single and married college students. In general, the students became more liberal or tolerant of the sexual behavior of "non-significant others", and they also became more liberal toward their own nudity and mutual masturbation, but their attitudes toward premarital sexual permissiveness did not change, nor did their other attitudes toward their own behaviors or the behaviors of their spouse.

In sum, these studies, plus others that have not been discussed, strongly indicate that sexuality courses do increase the tolerance of the students' attitudes toward the sexual practices of others. In this respect they become more liberal or permissive. A few studies also indicate that as a result of the course, the students become somewhat more comfortable with masturbation for themselves. On the other hand, the courses seem to have little impact upon the students' personal morality. More specifically, the beliefs that students have about their own sexual behavior with others do not appear to change. Thus, the critics' claim that the students' personal values become less moral is not substantiated by this evidence.

A caution, however, is in order. These studies rather clearly indicate that sex education can change the attitudes of students, if that is a clear intent of the course. In the courses described above, the instructors themselves were undoubtedly tolerant and supported a tolerant veiwpoint in the classroom. However, what happens if the instructor is intolerant and supports a dogmatic judgemental viewpoint? Will the students become more dogmatic, or will they become more tolerant nevertheless? These questions have not been answered, but deserve attention.

Effects Upon Behavior

Ultimately, most programs are concerned with their impact upon behavior. Unfortunately, very few studies have undertaken this task. There are, however, a few studies of college courses and other programs which can provide some evidence for the probable impact of junior or senior high school courses.

Only one study has carefully measured the impact of a course upon contraceptive use. Shipley (1974) examined the effects of a four week college unit on sex roles, relationships, and contraception. His sample size was sufficient (N=199), and he measured both pre and post scores, but he did not have a control group. This omission is probably not crucial because of the

short duration of the course. Between the pre and posttests, knowledge about contraception increased, and the number of students using effective means of contraception increased 33%, while the number of students using ineffective or no contraception decreased 57%. Clearly, these are dramatic figures for such a short course. Moreover, these behavioral changes occurred despite the fact that attitudes toward contraception did not change.

Other studies have focused upon other sexual behaviors. Bernard (1973) in his study of a college course described above found that both the experimental and the control students increased their sexual activity by roughly equal amounts. Thus, the course did not appear to have any clear impact upon those sexual behaviors measured.

Yarber (1978) studied the effects of a semester course at Purdue University. He also found that most differences between the experimental and control groups were not statistically significant. The few differences that did arise did not have any clear pattern and consequently they appear artifactual.

Zuckerman, Tushup, and Finner (1976) analyzed the behavioral impact of a college course taught at the University of Delware. Their study employed an experimental design and was based upon 234 subjects. Significantly, the students in the sexuality course had had far more sexual experience prior to the beginning of the course than the students in the psychology course used as a control. This finding has several implications. First, it accentuates the need to randomly assign students to the experimental and control group or to statistically control for the differences. Second, it suggests that surveys which use correlation techniques might obscure some effect of a sexuality course. Third, it emphasizes the need to analyze the change over time in experimental and control groups, rather than the difference between their post course behavior. Zuckerman, et al. provide additional findings. First, both their experimental and control students increased their sexual experience. Second, only two males and no females had their first coital experience during the course. Third, only five percent of the females had intercourse with a new partner during the course. This percentage is approximately typical for all courses. Finally, a few males indicated on their post questionnaires that they were homosexual, but there is strong reason to believe that they simply concealed their homosexual behavior on the first questionnaire. That is, there is little reason to believe that they had their first homosexual experience during the course.

Lance (1975) also investigated the impact of sex education upon the behavior of college students. He found that during the course which lasted a semester, none of the students engaged in sexual intercourse, oral-genital sex, or homosexuality, if they had not already done so prior to the course.

Wiechmann and Ellis (1969) whose survey is described above, did not find any relationship between previous exposure to sex education and either petting or sexual intercourse. Similarly, they failed to find any relationship between the grade in which the students received their sexuality instruction and sexual experience. As noted above, they failed to adequately measure the content of the sex education instruction, and thus this evidence is rather weak.

Finally, Spanier (1976) conducted a survey of 1177 randomly chosen college students across the country. He asked only a single question about participation in a sex education course, and this one question was not related to subsequent sexual behaior.

In sum, none of these studies carefully study the impact of junior or senior high school courses upon behavior. However, one of them suggests that units on contraception may increase the use of more effective contraceptives and decrease sexual activity with poor or no contraception. The studies also suggest that courses have little impact upon the other sexual behaviors measured by these studies. Specifically, these studies do not support the claim that sex education classes will increase the amount of sexual behavior. They also do not support the belief that courses will decrease sexual behavior.

Two additional types of programs should be described. Although they are not traditional sex education classes, their results are outstanding. The first program is discussed by Brann, et al. (1978). In St. Paul, Minnesota, a comprehensive health clinic was established on the school grounds. On campus the program provides sex education instruction, health exams, pelvic exams, and contraceptive follow-ups. Off campus the program actually provides contraception as well. Thus, the school clinic has an educational component and the staff interacts frequently with the students, but the program differs from the traditional sex education course. The results of the program are dramatic. Of those students who began using contraception, 86% were still using it after a year, and none of these students became pregnant during that time. More dramatically, the fertility rate for the high school declined by 56%. Because the staff carefully followed up students that dropped out of school, and also because the staff could demonstrate that this decline was not produced by legal abortion, these figures appear valid. If so, they are the most dramatic figures in the literature and the most solid evidence for the impact of a program upon teenage pregnancy.

This program in St. Paul somewhat resembles another program in Philadelphia (Dickens, Mudd, and Huggins, 1975). The latter program was developed by the University Hospital Teen Clinic. Social workers, nurses, and counselors provide lectures, discussions, and counseling to the high school students in their school and they make referrals to the hospital clinic for contraception. Significantly, the same staff members work with the teenagers in both locations, thereby providing a bridge between the school and the clinic. Of the first 170 students in the course, 61 became contraceptors and the number of pregnancies among these students appear to be low. Thus, the program appears to successfully reduce pregnancies. However, the quality of the data and the lack of data for a control group prevent a more definitive statement.

The second type of program that should be described are the sex education programs that are provided to teenage parents. A report by HEW described the Webster School in Washington, D.C. That program incorporated a great deal of counseling, therapy, and emotional support, as well as instruction in traditional sexuality topics. It substantially reduced the incidence of subsequent pregnancies. Similarly, a comprehensive program for school age

mothers at Johns Hopkins University has documented encouraging results. However, it should be realized that these programs are costly and involve far more than sex education instruction. They provide contraception, health care, and many other services.

As this report is being written, three other important studies are underway. In northern California, the Humboldt-Del Norte Family Planning Council is collecting data from questionnaires completed by all teenagers who seek pregnancy tests or abortions in the area. With this data, the council can calculate the pregnancy rates of each high school and observe the changes in these rates over time. Because some of the high schools have sex education classes, but others do not, the council can make informative comparisons. In a different study, Michael Carrera is completing an excellent evaluation of a sex education program in a special school for males. Finally, Susan Philliber and Elane Gutterman are finishing a thorough study of the Falls Church sex education program. That program is one of the best programs in the country and is summarized in Chapter 4.

Conclusions

Given the capabilities and limitations of schools in general, the effects of sex education programs are not surprising. First, sex education courses can clearly increase the students' knowledge about sexuality. Second, many programs do facilitate attitudinal change. Specifically, they tend to increase the students' acceptance or tolerance of the sexual practices of others. However, the programs appear to have less effect upon the students' personal value system which guides their own behavior. This is not surprising, because students are in the sex education classroom for a hundred hours or less, but they are exposed to their peers and to the media for thousands of hours and they are with their parents and family for a much greater amount of time. Third, the programs appear to have little effect upon the amount of various types of sexual behavior such as petting or sexual intercourse. Fourth, those courses which emphasize contraception may increase the use of effective contraceptive methods and may decrease both the use of ineffective methods of contraception and intercourse without contraception. Unfortunately, this conclusion is based upon only one college course and is therefore still tentative. Fifth, the experience of the St. Paul school health clinic and other programs which provide contraception strongly demonstrates that a program that integrates instruction and the provision of contraception can be highly successful in reducing pregnancies.

These conclusions are consistent with those of a different, but excellent review by Gordon, Scales, and Everly (1979). In that review, the authors also indicate that sex education programs for parents may increase the parents' comfort and frequency in discussing sexuality with their children, and that in turn, this greater communication causes the teenagers to delay their first experience of intercourse, and to use contraception when they finally do engage in sexual intercourse.

In addition to the findings presented above, the review of the literature for this chapter has uncovered several deficiencies in the literature. For example, the literature does not identify the major goals of sex education programs and then systematically map out the features and outcomes of programs

that may contribute to those goals. This is done in the next chapter of this volume. Second, the literature fails to identify and compare exemplary school and non-school programs. This is done in Chapters 4 and 5 of this report. Third, studies have not carefully analyzed the state guidelines which affect programs. This task is completed in Chapter 6. Finally, the field desperately needs improved methods of evaluating programs. In Volumes II and III are ideas for improving these methods and questionnaires for improving the instrumentation.

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Chapter 3:
IMPORTANT FEATURES AND OUTCOMES OF SEX EDUCATION PROGRAMS

Introduction

Although a few scholars have identified and rated important qualities of sex education teachers (c.f. Juhasz, 1970), they have not identified potentially important features, outcomes, or ultimate goals of programs. Moreover, they have not mapped out possible causal relationships among these variables. All of these things are done in this chapter. In addition it provides the ratings by experts of the importance of all identified features and outcomes.

Goals of Sex Education Programs

The first goal is the reduction of unwanted adolescent pregnancy. This goal is clearly important, provides the rationale for this contract, and provides the impetus for a great amount of nationwide activity. The large number of teenagers who become pregnant and the negative consequences of these pregnancies are briefly discussed in previous chapters and are described in much greater detail in the literature.

The second goal is the facilitation of positive and fulfilling sexuality. This goal should not be confused with the facilitation of sexual activity. Sex education professionals typically define "sexuality" broadly. When so defined, it refers not only to sexual intercourse, but to a broad range of interactions among people. For some adolescents, a more positive sexuality may result from reduced sexual activity, while for other adolescents, it may result from increased sexual activity. Thus, this goal actually involves the improvement of interpersonal relationships and psychological health.

This goal is intentionally broad, all encompassing, and somewhat vague. Whenever we attempted to make it more precise, either individuals or groups of people objected to it. As presently stated, this second goal is somewhat of a "catch-all" category like "maximizing happiness." It therefore encompasses many more specific goals other than reducing pregnancy.

Identification of Potentially Important Features and Outcomes

After reviewing the literature and discussing programs with professionals, we created a preliminary list of potentially important features and outcomes. We then extensively supplemented and clarified this list during a series of meetings with approximately 20 sex education experts. These experts included both adolescent members of sex education classes who were experts by virtue of their age and role, and adults who were professionals in the field of sex education. They also included experts with widely differing

viewpoints. In these meetings the distinctions and relationships among features, outcomes, and goals were clarified using the causal diagram in Figure 3-1. That is, the experts were asked to add 1) outcomes which might facilitate the two goals and 2) features which might produce the desired outcomes. These meetings were essentially a series of pretests. They were continued until increasingly minor and increasingly few changes in the list were suggested. At that point, there was a consensus that the items were both clear and exhaustive.

Despite the care in producing the list, an analysis of the subsequent ratings and further research indicated that a few items had been omitted. These few items were added to the list and rated at a subsequent time by a smaller number of experts. The final list of potentially important features and outcomes of sex education programs contains 239 items which are presented in Tables 3-2 and 3-3 below.

Methods of Rating the Features and Outcomes

To evaluate the importance of each item, we obtained a sample of experts and then asked that sample to rate each item.

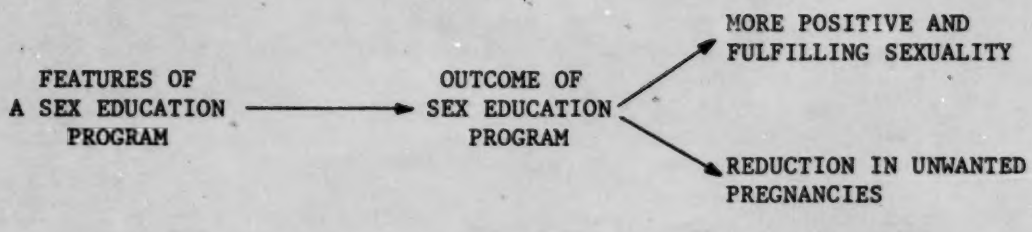
Selection of the Sample of Raters

Because an identifiable population of sex education experts did not exist, we could not take a random sample of that population. Nevertheless, we desired a sample that 1) contained experts, and 2) incorporated different opinions, geographic regions, etc. To obtain such a sample, a committee of nine prominent people in the field of sex education carefully selected 215 professionals all of whom had demonstrated competence in the field. Many of the professionals are members of AASECT, the only major national organization for sex educators. However, because AASECT members may differ in important respects from nonmembers, other professionals are also included. Significantly, the sample includes members 1) from all geographic regions of the country, 2) with different ideological viewpoints, and 3) with different professional relationships with adolescents (e.g., sex educators, adolescent counselors, and family planning counselors).

One caution should be mentioned. Although the sample includes professionals with different ideological orientations, it is undoubtedly rather liberal in general, and undoubtedly includes few very conservative members who are opposed to sex education. However, this does not mean that the sample is biased. Rather, it reflects the fact that few sex education professionals are strongly opposed to sex education. Most people who are ideologically opposed to sex education in general or to many specific features of programs are not experts in the field.

One hundred thirteen professionals rated and returned the items. This is a response rate slightly greater than 50%. Because a few of the ratings apparently contained errors, they were excluded, leaving one hundred usable ratings. Thus, the final response rate is slightly less than 50%. This response rate is reasonably high by most social science standards. Moreover, an analysis of the respondents indicates that the final sample contains the same geographic, ideological, and professional diversity discussed above.

FIGURE 3-1: INITIAL CAUSAL RELATIONSHIPS AMONG MAJOR GROUPS OF VARIABLES AND GOALS


FEATURES OF A SEX EDUCATION PROGRAM
OUTCOME OF SEX EDUCATION PROGRAM
MORE POSITIVE AND FULFILLING SEXUALITY
REDUCTION IN UNWANTED PREGNANCIES

In sum, the sample is not random, but the caliber of its members and the diversity of its members make it an important sample of opinion.

Rating of the Items

The professionals rated each item on a 1 to 9 scale with "1" and "2" representing "not-at-all important," "5" representing "moderately important," and "8" and "9" representing "extremely important." Half the professionals rated each item according to its importance in reducing teenage pregnancy, while the other half rated each item according to its importance in facilitating a satisfying and fulfilling sexuality.

For each criterion and for each item, both the mean and median rating were calculated. These measures provide summaries of the opinions of the experts.

The correlation coefficient between the means and medians across the items was .98 for one criterion and .99 for the other. Because these correlations are so high, either the mean or median can safely be used. However, we selected the mean for two reasons. First, the means tended to be slightly lower, and hence are more conservative. Second, the mean ratings are lowered substantially if any of the ratings of the given item are very low. In contrast, the median may be unaffected by a few very low ratings. Thus, in this second manner, the mean is more conservative.

Methods of Increasing and Evaluating the Quality of the Data

Procedures for Enhancing the Data Quality

Because the number of items to be rated was large, fatigue or lack of concentration may have produced error. To reduce this error, we used two procedures. First, we randomly ordered the groups of items on each list sent to the raters. That is, approximately 100 different versions of the lists were sent to the raters. Although each list may have been affected by fatigue or response errors, these errors should be randomly distributed, and accordingly, the mean of the ratings for each item is much less likely to be affected by these errors.

Second, we excluded from the final analysis all ratings which contained readily visible response errors. Those ratings which were eliminated most commonly contained a preponderance or series of "9's." Less frequently they contained other clear response sets. Those raters who rated many successive items as "extremely important" may have believed that all those items were extremely important. However, they probably used insufficient care in rating the items. Because the more conservative alternative was to remove these questionable ratings, they were excluded. However, a comparison of the mean ratings both with and without these responses indicates that the mean ratings changed only slightly (never more than .2) and that the major conclusions remain the same. In sum, randomly ordering the groups of items and excluding ratings with clear response sets probably eliminated much of the error in the ratings.

Tests of the Effects of Political Orientation and Sample Bias

Sex education in general is controversial and specific features of programs (e.g., the discussion of contraception, abortion, and homosexuality) are especially controversial. If ideological orientations of the professionals strongly affected their ratings, then the validity and the value of the ratings are substantially reduced.

To test the extent to which ideological orientations affected ratings, we conducted three tests. First, and most important, we observed the relationship between whether or not an item was controversial and the ratings of that item (see Table 3-1). We considered controversial those items involving religious values, advocacy of sexual intercourse, sexual techniques, masturbation, oral sex, prostitution, rape, homosexuality, alternative life styles, contraception, and abortion. Although other items may be somewhat controversial among some groups, these topics are clearly the topics which have created the greatest controversy in this country. Items were also divided into three groups according to their ratings. In the first group are those items which were rated as extremely important or very important by nearly all the experts. In the second group are those items which were rated extremely important by a majority of the raters, but which were given lower ratings by a significant number of other experts. Finally, in the third group are those items which were more commonly rated as only moderately or not-at-all important.

If the professionals were especially liberal on controversial features and allowed their conservative-liberal orientations to affect their ratings of importance, then a disproportionately large number of controversial items would have been rated uniformly as very important and would appear in the first group. Table 3-1 demonstrates that this is not the case. In fact slightly smaller percentages of controversial items than noncontroversial items were uniformly considered very important (.39 versus .43 for pregnancy reduction and .46 versus .49 for fulfilling sexuality). The differences in these percentages should not be emphasized, however, for they are neither large nor statistically significant. If the professionals were very conservative and allowed their biases to affect their ratings, then the percentage of controversial items rated as moderately or not-at-all important would be significantly less than the percentage of noncontroversial items in that category. Again, this is not the case. On one criterion the difference is small and in the predicted direction; while on the other criterion the difference is small and in the opposite direction. In neither case are the differences statistically significant. Finally, if some experts were liberal and others were conservative, and if they allowed their orientation to affect their ratings, then the percentage of controversial items falling into the second group (containing many high ratings and some moderate or low ratings) should substantially exceed the corresponding percentage for noncontroversial items. For pregnancy reduction there is a small, but statistically insignificant difference (17% versus 11%), while for fulfilling sexuality the difference is truly negligible (15% versus 14%). In general, the lack of a relationship between the amount of controversy of an item and the rating of the item strongly suggests that ideological orientation had little impact upon the ratings.

Table 3.1 Relationship Between Whether Items Are Controversial and Ratings of Items (N = 214)

	Controversial Items		Uncontroversial Items	
Items Rated "Very Important" by Most Experts	39%*	46%**	43%	49%
Items Rated "Very Important" by a Majority of Experts and Rated Less Important by Some Experts	17%	15%	11%	14%
Items Rated Less Than "Very Important" by a Majority of Experts	43%	39%	46%	37%
Totals	100%	100%	100%	100%

* Percentages on the left represent the first criterion, "Importance in Reducing Teenage Pregnancy."

** Percentages on the right represent the second criterion, "Importance in Facilitating a Positive and Fulfilling Sexuality."

As a second test of the extent to which ideological orientation affected the ratings, we compared the items in the second group for each criterion. If ideological orientation strongly affected the rating of some items and caused them to fall into the second group, then 1) the two groups of items should contain the same items and 2) these items should be the controversial items. Neither of these events occurred. Of the 51 different items that fell into either of the two groups, only 8 were in both groups. More importantly, only two of the eight items were controversial.

Finally, as a third test we factor analyzed the items found in the second group of each criterion. In both factor analyses the first factors explained more than 30% of the total variance. Of the twelve items with factor loadings greater than .60 on these major factors, fewer than half were controversial items. Moreover, other factors did not represent a "controversial" factor.

Each of these tests clearly has its own weaknesses. Nevertheless, all three of them indicate that the ideological positions of the members of the sample did not cause them to rate some features higher than others. That is, liberal-conservative ideologies did not affect the relative rating of the items.

However, a caveat is in order. Professionals in sex education are probably more liberal than the public in general, and these more liberal opinions are probably reflected in the data. Thus the ratings of the experts would probably be higher in general than ratings by the public if the latter were to be measured. However, it should also be realized that these professionals are far more knowledgeable than the general public about the impact of programs upon adolescent relationships and pregnancies.

Effects of Sample Size

One hundred professionals rated the items, with half of them rating the items on each criterion. Thus, each of the means is based upon a sample of 50, not 100 ratings. Although a larger sample would have increased the accuracy of the results, the existence of considerable agreement on many items suggests the accuracy of the mean ratings is very good. Specifically, the 95% confidence interval is only ± 0.3. Thus, if the sample mean is 6.0, the true mean is probably between 5.7 and 6.3. Those items with the highest mean ratings have the greatest consensus, and thus their accuracy is even greater.

Summary of Data Quality

In sum, the data appear reasonably reliable, valid, and accurate for the following reasons:

1) The pretesting of all the items improved the clarity of the items and ensured that most important or potentially important items were included.

2) Although the sample was not random, it included many well-known professionals in different professional roles, in different regions, and with different ideological positions. Moreover, three tests indicated that ideological position probably had little impact on ratings.

3) Although the sample sizes are not large, the sampling error due to sample size is small, because the means of ratings are presented and used in the discussion and because there was considerable agreement (low variance) within each item.

4) We excluded all ratings which included clear response sets or errors caused by fatigue, lack of concentration, etc.

Results

Importance of Items

In this study an item is considered important if it is rated as extremely important (a rating of 8 or 9 on the 1 to 9 scale) by at least 50 percent of the professionals. This criterion, like all cut-off points, is somewhat arbitrary. However, there are three reasons for this choice. First, it is traditional, logical, and natural to discuss a "majority" opinion. Second, this criterion causes a reasonable number of items to be included. Third, this criterion causes many items commonly discussed in the literature to be included, and it causes items deemed less important by the literature to be excluded.

The group of items rated extremely important contains items with varying unanimity. That is, some of the items were rated extremely important by nearly all the professionals, while others were rated extremely important by only 50 percent. Although the mean of a distribution typically provides information about the center of a distribution, and not about the consistency of the scores, the mean rating of each item does provide considerable information about the unanimity of opinion for these items considered important. (This is partially caused by the fact that all ratings are based upon a 1 to 9 scale.) An analysis of the distributions indicates the following. If the mean rating of an item exceeds 8.0, then at least 70% of the experts rated the item as extremely important (8 or 9) and at least 90% rated it as very important (7, 8, or 9). Thus, these items are clearly considered very important by nearly all the professionals. If the mean rating of an item is between 7.5 and 8.0, then at least 56% of the experts rated it as extremely important, and 72% rated it as very important (7, 8, or 9). Thus, these items are supported by a clear consensus, but they have less unanimity than the items with means greater than 8.0. Finally, the items with a mean rating between 7.0 and 7.5 have a substantial proportion of lower ratings. This indicates that either the items reflect disagreement or the items are important in some settings, but not in others. None of the items rated extremely important on either criterion by 50 percent of the experts had a mean less than 7.0 on that criterion.

All of the items were rated on two criteria, importance in reducing unwanted pregnancy and importance in facilitating a positive and fulfilling sexuality. An important theoretical question is whether or not these two goals are compatible. Are some features important in reducing pregnancy unimportant in facilitating good relations with others, or vice versa?

To fully answer this question we conducted two tests. First, for each item we found the difference between the two means representing the two
(text continued on page 49)

TABLE 3-2. FEATURES OF PROGRAMS WITH MEAN RATING FOR EACH CRITERION

PART 1. TOPICS FOR DISCUSSIONS AND ACTIVITIES

Items Rated Extremely Important***

Mean #1*	Mean #2**	
		PHYSIOLOGY
7.8	7.6	discussions of anatomy and physiology (including physical changes during adolescence)
7.5	7.4	discussions of the biological aspects of human reproduction
8.4	8.0	discussions of the probability of becoming pregnant
7.5	7.3	discussions of the process of pregnancy and childbirth
7.6	7.9	discussions of normal body variations
		SEX RELATED ACTIVITIES
7.5	7.5	discussions of dating, necking, and petting
7.4	7.7	discussions of emotional and social aspects of sexual intercourse
7.5	7.7	discussions of the role of love and commitment in sexual activity
8.1	8.2	discussions of human sexuality as an aspect of total personality
8.1	7.5	discussions of the relationship between one's self-image and one's sexual behavior
8.0	8.0	discussions of emotional and social needs and changes during adolescence
7.7	7.3	discussions of the advantages and disadvantages of premarital sexual activity
8.4	8.0	discussions of the probability of becoming pregnant
7.3	7.3	discussions of the social consequences of adolescent pregnancy and marriage
7.0	6.8	discussions of the economic consequences of adolescent pregnancy
8.0	7.6	discussions of the student's experiences, attitudes, and feelings about sexual activity
6.9	8.2	discussions of the range of normal sexual behavior
6.1	7.3	discussions of alternative life styles
6.2	7.4	discussions of homosexuality
7.4	8.0	discussions of masturbation

* This is the mean rating on the importance of reducing pregnancy.
** This is the mean rating on the importance of facilitating a positive and fulfilling sexuality.
*** These items received a rating of "8" or "9" on a 1 to 9 scale by a majority of the sex educational professionals surveyed.

		VD
6.6	8.0	discussions of venereal disease or sexually transmitted disease
		MYTHS
7.6	8.2	discussions of common myths (e.g., penis size determines pleasure or masturbation causes mental illness)
		VALUES
8.0	7.3	discussions of the individual student's values
7.7	7.2	discussions of long range life goals (e.g., children and careers)
8.0	7.6	discussions of the student's experiences, attitudes, and feelings about sexual activity
8.0	7.9	discussions of the student's experiences, attitudes, and feelings about sex roles
		PRESSURE, EXPLOITATION, AND ASSERTIVENESS
7.8	8.0	discussions of peer pressure
7.9	7.1	discussions of sexual exploitation among adolescents
8.3	7.8	discussions of avoiding unwanted sexual experiences
7.1	6.5	discussions of assertiveness techniques
		CONTRACEPTION
7.9	7.7	discussions of family planning
8.1	8.1	discussions of the advantages and disadvantages of each contraceptive method
8.0	8.1	discussions of fears and fallacies about each contraceptive method
8.3	8.1	discussions of the effective use of different birth control methods
8.0	7.8	discussions of sources of sex-related information and of contraception (e.g., specific family planning clinics)
		SKILLS
7.5	7.6	discussions of the appropriate concern and responsibility for other people
8.1	7.9	discussions of decision-making and problem solving techniques
7.5	7.3	discussions of how to care about and be supportive of others
7.9	7.6	discussions of how to improve communication skills with with peers, parents and others
7.8	7.5	discussions of how to resolve interpersonal conflicts with peers, parents and others

Items Not Rated Extremely Important****

7.2	6.7	discussions of sexual assertiveness
6.1	5.6	discussions of the student's own individual fertility
6.4	6.2	discussions of the laws pertaining to birth control methods
7.0	6.8	discussions of the economic consequences of adolescent pregnancy
7.3	7.3	discussions of the social consequences of adolescent marriage
6.8	7.0	discussions of human sexual response
6.7	6.6	discussions of the effects of drugs and alcohol on sexual behavior and response
5.2	5.4	discussions of sexual techniques
5.9	6.2	discussions of oral sex
4.9	5.4	discussions of prostitution
5.3	6.2	discussions of deviant sexual behavior
5.1	6.1	discussions of sexual dysfunctions (premature ejaculation, inorgasmic disfunctions, etc.)
6.8	7.1	discussions of gynecological exams
6.8	6.7	discussions of the effects of the mass media on sexuality
6.0	7.3	discussions of rape
7.2	7.2	discussions of abortion
6.8	7.3	discussions of sources of help for sexual problems
4.8	5.6	discussions of pornography
4.7	6.0	discussions of the relationship between sex and aging
5.5	5.6	discussions of problems of overpopulation

**** These items did not receive a rating of "8" or "9" on a 1 to 9 scale by a majority of the sex educational professionals surveyed.

PART 2: TEACHER CHARACTERISTICS

Items Rated Extremely Important

MEAN #1	MEAN #2	
		KNOWLEDGE
8.4	8.4	teacher knowledge about facts, issues, materials, etc., relevant to human sexuality
7.7	8.0	teacher with previous participation in courses or workshops relevant to human sexuality
7.4	7.0	teacher who reads about recent research in human sexuality
		ENTHUSIASM
8.4	8.6	teacher genuinely enthusiastic about teaching sex education
		SUPPORTIVE DISCUSSION SKILLS
8.9	8.8	teacher who can discuss aspects of human sexuality with comfort
8.8	8.6	teacher capable of effectively handling questions potentially embarrassing to either the teacher or the student
8.6	8.4	teacher sensitive to the varying vulnerability of the students
8.8	8.7	teacher with genuine warmth, empathy, openness, concern, and respect for others
8.7	8.6	teacher capable of gaining the trust of students
8.5	8.5	teacher with good rapport with students
8.7	8.7	teacher capable of creating a classroom environment conducive to the expression of feelings and opinions
8.5	8.5	teacher whose teaching is nonjudgmental
7.5	7.4	teacher who accepts alternative sexual life styles
8.8	8.7	teacher with good listening skills
7.9	8.1	teacher whose guilt, anxieties, etc., about his/her sexuality do not affect his/her classroom instruction
		TRUST OF ADMINISTRATION AND COMMUNITY
7.8	8.1	teacher capable of gaining the trust of the administration and the community

Items Not Rated Extremely Important

2.1	2.1	teacher younger than 35
1.8	1.9	teacher older than 35
1.5	2.0	male teacher
1.5	1.9	female teacher
4.0	4.2	team teaching
5.2	5.8	team teaching with both sexes represented
4.9	4.3	teacher with professional experience in family planning (e.g., a doctor, counselor, or educator in a clinic)
5.1	5.2	teacher with values and a life style similar to that of the community
6.4	6.4	teacher capable of teaching "chastity" as a valid system

PART 3: CLASSROOM CHARACTERISTICS

Items Rated Extremely Important

MEAN #1	MEAN #2	
		SUPPORTIVE CLASSROOM ATMOSPHERE
8.3	8.2	trust among the students and teacher
8.2	8.4	good rapport among students and the teacher
8.5	8.7	classroom atmosphere with genuine warmth, empathy, openness, concern, and respect for others
8.5	8.5	classroom environment conducive to the expression of feelings and opinions
8.4	8.5	the discussion of aspects of human sexuality with comfort
8.6	8.5	the effective handling of questions or comments potentially embarrassing to either the teacher or student
8.7	8.6	comfortable atmosphere for asking questions
8.3	8.5	confidentiality of views expressed by students in class
8.3	8.3	a nonjudgmental classroom environment
7.7	7.7	advocacy of sexual activity consistent with the individual's own values
7.0	7.2	advocacy of sexual activity consistent with the use of birth control
8.4	8.3	recognition of the differing values of the adolescents
7.8	7.8	recognition of the differing needs of the adolescents from diverse socio-economic backgrounds
8.6	8.4	recognition of the varying vulnerabilities of the students
		KNOWLEDGE OF FACTS AND ISSUES
8.1	8.2	discussions and other activities based upon a solid knowledge of the facts, issues and materials relevant to human sexuality
		FREEDOM TO EXPLORE TOPICS
8.6	8.6	freedom to explore any issues and topics raised by students about human sexuality
		RESOURCES AND ACTIVITIES
8.1	8.1	class discussions led by the teacher with considerable student input
7.2	7.1	class discussions with teenage parents about the experiences and responsibilities of parenting
7.3	7.3	group exercises designed to increase trust, sharing of feelings, sensitivity, etc.
7.0	7.1	role playing and psycho-drama as a learning tool
7.6	7.4	opportunity to examine and handle contraceptives
7.2	7.7	appropriate films and other resource materials
7.8	7.9	assignments aimed at improving skills as well as knowledge
8.0	8.0	assignments aimed at affective as well as cognitive learning
		CO-ED CLASSES
7.3	7.8	co-educational classes

Items Not Rated Extremely Important

6.8	6.9	use of language appropriate to the cultural characteristics of the adolescents rather than technical jargon
1.8	1.8	discouragement of all nonmarital sexual activity
5.6	5.7	advocacy of sexual activity consistent with the individual's religious and familial background
5.4	5.5	lectures by the teacher
5.3	5.5	experts as speakers
5.4	5.6	class discussions with the parents of the adolescents
6.9	6.8	small class discussions led by student "peer counselors"
6.9	7.0	experimental objectives (measurable goals for the course)
6.4	6.4	behavioral objectives (measurable goals for the course)
6.2	6.3	appropriate textbooks
5.2	5.8	nonacademic reading list that deals with sexuality (e.g., My Secret Garden)
4.8	4.8	separate discussion groups, all male or all female, when the course is co-educational
2.3	2.7	all female or all male classes

PART 4: PROGRAM CHARACTERISTICS

Items Rated Extremely Important

MEAN #1	MEAN #2	
		COURSE CREDIT
7.3	7.4	full academic credit for courses
		INTEGRATION OF MATERIAL INTO OTHER CLASSES
8.7	8.6	incorporation of sex education into primary schooling (K-12)
		SPECIAL PROVISIONS
7.7	7.7	special provisions for disadvantaged participants (e.g., deaf and handicapped students)
7.8	7.5	availability of individual counseling
		TIME AND PLACE
7.9	7.7	convenient time for programs
7.5	7.2	instruction on the school grounds during school hours
		INVOLVEMENT OF DIFFERENT GROUPS
7.5	7.8	involvement of the parents and community in the initial development of the program
7.7	7.7	involvement of professional experts in the initial development of the program
7.5	7.7	involvement of the students in the initial development of the program
8.2	8.3	continued participation of the students in the program
		EVALUATION AND DEVELOPMENT
8.2	8.2	continued evaluation and development of the program
		TRUST BY ADMINISTRATION AND COMMUNITY
7.8	8.1	trust in the teacher by administration and community
7.2	7.9	continued rapport among the sex education teachers, administrators, and community

Items Not Rated Extremely Important

6.3	5.9	coverage of sex related topics in the school newspaper
6.9	6.4	availability of teen rap sessions after school
5.7	5.3	provision of contraceptives
7.2	6.9	classes for the students' parents which complement the students' classes
5.5	5.8	confidentiality of participation in the sex education program
5.1	4.6	instruction on the school grounds after school hours
5.7	4.4	convenient location off the school grounds
6.1	6.5	concentration of sex education topics in a specific sex education class
6.5	6.3	dispersion of sex education topics in different classes (e.g., health, biology, social studies, etc.)

6.7	6.7	continued participation of the parents and community in the program
6.8	6.7	continued participation of the professional experts in the program

TABLE 3-3: OUTCOMES OF PROGRAMS WITH MEAN RATING FOR EACH CRITERION

PART 1: KNOWLEDGE

Items Rated Extremely Important***

MEAN #1*	MEAN #2**	
		PHYSICAL DEVELOPMENT AND HUMAN REPRODUCTION
6.9	7.5	greater understanding of physical changes during adolescence and development differences between the sexes
7.5	7.3	greater understanding of human reproduction
		SOCIAL AND SEXUAL ASPECTS OF ADOLESCENTS
7.5	7.7	greater understanding of the emotional and social needs and changes during adolescence
7.1	7.3	greater understanding of the importance of love and commitment in sexual relationships
8.2	8.0	greater understanding of sexual exploitation among adolescents
		SEXUAL ACTIVITY
7.9	7.8	greater understanding of the emotional and social aspects of sexual intercourse
7.1	7.4	greater understanding of the nonbiological aspects of sexual intercourse
7.4	7.2	greater understanding of alternatives to sexual intercourse (e.g., masturbation, oral sex, etc.)
		BIRTH CONTROL
8.3	8.0	greater understanding of where to obtain birth control
8.1	8.0	greater understanding of advantages and disadvantages of alternative methods of birth control
8.5	8.2	greater understanding of the effectiveness of birth control methods
8.3	8.2	greater understanding of the effective use of different birth control methods
		PROBABILITY OF BECOMING PREGNANT
8.5	7.8	greater understanding of the probability of becoming pregnant
8.4	8.0	greater understanding of the need for contraception
		ADOLESCENT MARRIAGE AND PARENTHOOD
8.2	7.7	greater understanding of the problems of adolescent marriage and parenthood

* This is the mean rating on the importance of reducing pregnancy.
** This is the mean rating on the importance of facilitating a positive and fulfilling sexuality.
*** These items received a rating of "8" or "9" on a 1 to 9 scale by a majority of the sex eductional professionals surveyed.

		VENEREAL DISEASE
6.1	7.6	greater understanding of venereal disease
		MYTHS
7.2	7.9	greater understanding of common myths about sexuality

Items Not Rated Extremely Important****

7.1	7.1	greater understanding of dating, necking, and petting
6.7	7.0	greater understanding of human sexual response
6.1	6.0	greater understanding of methods of satisfying one's sexual partner
5.8	5.9	greater understanding of sexual techniques of arousal and their value
7.4	7.3	greater understanding of sex role behaviors
6.7	6.8	greater understanding of the effects of drugs and alcohol on sexual behavior and sexual responses
4.8	6.1	greater understanding of the relationship between sex and aging
6.4	6.6	greater understanding of exploitation of sexuality by media
5.3	5.7	greater understanding of pornography and its role in affecting sexual expectations
5.2	5.6	greater understanding of problems of overpopulation
6.8	6.7	greater understanding of sources of help for sexual problems
7.0	6.6	greater understanding of practical and ethical considerations regarding abortion
6.8	6.2	greater understanding of laws pertaining to abortion
6.9	6.4	greater understanding of where to obtain abortions
7.2	7.2	greater understanding of anatomy and physiology
6.0	5.9	greater understanding of laws pertaining to birth control methods

**** These items did not receive a rating of 8 or 9 on a 1 to 9 scale by a majority of the sex education professionals surveyed.

PART 2: CHANGES IN UNDERSTANDING OF SELF

Items Rated Extremely Important

MEAN #1	MEAN #2	
		VALUES AND GOALS
8.2	8.5	greater understanding of one's own values and the values of others
7.8	7.4	greater understanding of long-range life goals (e.g., children or careers).
		NEEDS
8.6	8.5	greater understanding of one's own emotional needs
		SKILL AND BEHAVIOR
8.3	7.9	greater understanding of one's own interpersonal skills and behavior
		SEXUAL RESPONSE
7.6	7.6	greater understanding of one's sexual response

PART 3: CHANGES IN VALUES

Items Rated Extremely Important

MEAN #1	MEAN #2	
		PERSONAL RESPONSIBILITY
8.8	8.8	greater understanding of ones responsibility for his/her own behavior
		BODY VARIATIONS
6.4	7.8	greater acceptance of others' body variations (e.g., beauty, penis and breast size, etc.)
7.3	8.1	greater acceptance of one's own body variations
		SEX ROLES
7.2	7.8	greater acceptance of variations in filling sex roles
8.0	7.9	greater ability to formulate one's own sex role standards
7.6	7.7	greater ability to question sex role behavior expectations
		SEX GUILT
7.8	8.0	reduction of sexual guilt
7.9	8.0	greater acceptance of one's level of sexual activity (from abstinence to intercourse)
		SEXUAL PRESSURE
7.8	7.5	greater opposition to the use of subtle pressure in sexual activity
7.4	7.6	greater opposition to the use of physical force in sexual activity
		BIRTH CONTROL
8.0	7.8	greater acceptance of birth control
		ALTERNATIVES TO INTERCOURSE
7.3	7.0	greater acceptance of alternatives to sexual intercourse (e.g., masturbation, oral sex, etc.)
		SEXUAL LIFE STYLES
6.3	7.6	greater acceptance of alternative life styles for others
7.1	7.7	greater understanding of the range of normal sexual behavior

Items Not Rated Extremely Important

6.4	6.6	greater acceptance of various methods of satisfying one's sexual partner
5.8	6.9	greater acceptance of alternative life styles for self (e.g., homosexuality, monogamy, etc.)

PART 4: CHANGES IN SELF-ESTEEM

Items Rated Extremely Important

MEAN #1	MEAN #2	
		GENERAL
8.6	8.5	greater general self-esteem
		SOCIAL
7.6	7.4	reduction of fear of rejection by peers
		SEXUAL
7.9	8.5	greater sexual self-esteem

PART 5: CHANGES IN INTERACTION SKILLS

Items Rated Extremely Important

MEAN #1	MEAN #2	
		DECISION MAKING
8.5	8.4	greater ability to engage in rational decision making on one's own
8.5	8.2	greater confidence in one's own decisions
7.9	7.8	greater ability to engage in joint decision making
		GENERAL COMMUNICATION
7.9	7.5	greater ability to express oneself on a personal level
7.2	7.5	greater ability to listen
8.0	8.1	greater ability to directly and clearly communicate feelings, both verbally and nonverbally
		DISCUSSION OF SEXUAL NEEDS
8.5	8.5	greater ability to discuss sexual behavior with one's potential or actual sexual partner
7.4	7.6	greater ability to communicate one's own sexual needs
		DISCUSSION OF SEX
7.1	7.1	greater ability to discuss sexual issues with peers
		SEXUAL ASSERTIVENESS
8.4	8.1	greater ability to assert oneself when refusing to participate in sexual activities
		BIRTH CONTROL ASSERTIVENESS
8.6	8.3	greater ability to assert oneself when insisting on the use of birth control
		CARING
7.1	7.8	greater ability to care about and be supportive of others
7.7	7.9	greater acceptance of concern and responsibility for others
		CONFLICT RESOLUTION
7.5	7.6	greater ability to resolve interpersonal conflicts with peers, parents, and others

Items Not Rated Extremely Important

6.8	6.6	greater ability to physically communicate without sexual overtones
6.5	6.7	greater ability to discuss sexual issues with parents
6.6	6.7	greater ability to discuss sexual issues with sex educators, planned parenthood counselors, etc.
4.4	4.9	greater ability to discuss sexual issues with religious leaders

6.0 6.4 greater ability to inform parents about need for physical affection

PART 6: CHANGES IN FEAR OF SEX-RELATED ACTIVITIES

Items Rated Extremely Important

MEAN #1	MEAN #2	
		HETEROSEXUAL INTERACTION
7.3	7.9	reduction of fear of interacting with members of the opposite sex
		SEXUAL ENJOYMENT
7.1	7.5	greater acceptance of the enjoyment of sexual activity
8.0	8.3	greater understanding of the positive role of sexuality in one's life
		SEXUAL EXPERIMENTATION
6.9	7.1	greater comfort with sexual experimentation consistent with one's own sexual values
		DISCUSSION OF SEXUAL PROBLEMS
7.4	7.7	greater comfort in seeking advice or help for sexual problems
6.5	7.3	greater comfort with sexual language
7.5	7.8	greater comfort in discussing sexual issues with peers
		USE OF BIRTH CONTROL
8.0	8.1	greater comfort in asking for and getting information about contraception
8.1	7.9	greater comfort in buying or obtaining contraception
7.8	7.9	greater comfort in using contraception
		VD TREATMENT
6.0	7.5	reduction of fear of tests for venereal disease
		GYNECOLOGICAL EXAMS
7.2	7.6	reduction of fear of gynecological exams
		BODY FUNCTIONS
7.1	8.2	greater comfort with one's own bodily functions (e.g., menstruation)

Items Not Rated Extremely Important

6.8	6.4	reduction of fear that parents will discover one's use of birth control
6.5	6.6	reduction of fear of initiating sexual activity

criteria. For items considered extremely important by a majority of the raters, the mean absolute difference was found. The mean absolute difference is simply the average of the differences after any minus signs have been removed. If minus signs had not been eliminated, then a negative difference would have cancelled a positive difference and the mean of the difference would have been misleadingly small. The mean absolute difference is only .3 and the largest difference is only 1.5. This method clearly indicates that the two goals are highly consistent.

Second, we correlated the means of the items on the first criterion with the means of the items on the second criterion, and then found the same correlation for the medians. Both correlations are .95. This also strongly suggests that the two goals are compatible and that features and outcomes of programs important to the one goal are also important to the other. In fact, these correlations are so high that either criterion can be used in place of the other. Consequently, in the remainder of this chapter we shall simply refer to "importance" without referring to the criterion.

In Tables 3-2 and 3-3 are all the items rated by the professionals. All extremely important items are organized both by content and by the results of a factor analysis. Items not rated as extremely important are listed at the end of each section. For all items in the tables the means on both criteria are provided.

The tables clearly demonstrate that many features and outcomes are perceived as potentially important in reducing unwanted adolescent pregnancies and facilitating a positive sexuality. All of these important features and outcomes should be measured. The questionnaires discussed and provided in the following chapters provide a method of doing so.

Important Features of Programs

Throughout the nation many sex education programs focus primarily upon anatomy and physiology. Typically students claim that they already know this material, and they react with apathy. Some students request more interesting material on sexual behavior.

The ratings of the experts support these students' feelings, for the experts clearly indicate that numerous other topics are extremely important, especially contraception, sex-related activities, myths, values, exploitation and assertiveness, the emotional and social aspects of sexual activity, and numerous skills.

A number of somewhat controversial topics were consistently rated as extremely important by the experts. These topics included the advantages and disadvantages and the emotional and social aspects of premarital sexual activity, masturbation, and contraception. Other topics including rape, abortion, alternative life styles, and homosexuality were deemed extremely important by a majority of the experts, but some of the professionals rated them less important. With near unanimity, the experts considered it very

important that the students have the freedom to explore any issue they raise about human sexuality. Also with near unanimity, the experts believed that the discouragement of all nonmarital activity was unimportant.

Moreover, the experts made clear that topics should not be covered superficially. For example, when contraception is discussed, it should cover at minimum the advantages and disadvantages of each method, the fears and fallacies associated with each method, the effective use of each method, and the addresses of specific family planning clinics or other institutions where contraception can be obtained. Similarly, discussions of values should include discussions of the student's values, their long-range goals, and their experiences, attitudes, and feelings about various sexual activities and sex roles.

Finally, the experts emphasized the importance of numerous skills, especially decision-making and problem-solving skills, communication skills, methods of resolving interpersonal conflict, and assertiveness techniques. In addition to discussions of these topics, assignments and class exercises are needed to facilitate the development of these skills. Reality testing and practice are essential elements in the teaching of these skills for they require more than simple cognitive understanding.

With great consistency, the experts indicated that these topics should be covered in a supportive classroom atmosphere. This atmosphere should have genuine warmth, empathy, openness, concern, respect, and trust. It should facilitate the asking of questions and the expression of feelings and opinions. It should be nonjudgmental. It should also recognize the differing needs, values, experiences, and vulnerabilities of the students. The freedom to explore topics raised by the students is also important to the creation of this atmosphere.

According to the experts, one of the most important qualities of a teacher is his/her ability to teach sex education enthusiastically and comfortably and to create the type of classroom atmosphere just described. In addition, however, the teacher must be knowledgeable about relevant facts, issues, and materials, and must be capable of gaining the trust of the administration and community. The age and sex of the teacher were considered completely unimportant.

A number of program characteristics were considered important. Of greatest importance is the integration of sex education material into all grades (K-12) and the involvement of parents, professionals, and students in the initial and continued development of the program.

Important Outcomes of Programs

Thus far this discussion has focused upon items that represent features of programs. The remaining discussion focuses upon the outcomes for the participants of the program.

Sixty-seven of the outcome items were rated extremely important by a majority of the experts. Whereas the features of programs could logically be divided into topics of discussion, teacher characteristics, classroom

characteristics, and program characteristics, the outcomes of programs do not have such a logical and obvious structure. The structure presented in Table 3-3 was determined primarily by an orthagonal factor analysis of all the items. Approximately one hundred adolescents from different parts of the country and with different social and ethnic backgrounds provided the data for the factor analysis. This analysis is described more fully in Volume II, Chapter 5.

In the present structure, there are six major groups of items: changes in objective knowledge, changes in understanding of self, changes in values, changes in self-esteem, changes in interaction skills, and changes in fear of sex-related activities. According to the experts, these changes will in turn facilitate positive relationships between people and reduce pregnancies.

As might be expected, the most highly rated knowledge items are those involving a greater understanding of 1) the social and sexual aspects of adolescence, 2) the probability of becoming pregnant, and 3) birth control. A greater understanding of physical development, human reproduction, sexual activity, venereal disease, myths about sexuality, and adolescent marriage and parenthood were also rated very important.

The second group of items, changes in understanding of self, differs from the first group of knowledge items in that they do not involve objective or factual knowledge, but do involve personal insights. They include greater clarity of one's own needs, values, goals, sexual response, skills, and behavior.

The third group involves changes in values. Four of the items are acceptance of responsibility for personal behavior, acceptance of body variation, acceptance of alternative sex roles, opposition to subtle pressure, and opposition to physical force in sexual activity. Given the normative structure of our society, these are not controversial. They include a reduction of sexual guilt, or acceptance of birth control, an acceptance of alternative life styles for others, and an acceptance of alternatives to sexual intercourse. Although there is much debate about the morality of these outcomes in our society, they were rated extremely important by most of the experts.

From a theoretical standpoint one might question how a reduction of sexual guilt will reduce unwanted pregnancy. A possible answer is provided in the literature which suggests very clearly that sexual guilt discourages the recognition of one's sexual activity and thereby hinders the use of effective contraception. Thus, when guilt is reduced, contraception is more likely to be used and pregnancy is less likely to occur.

Despite this rationale for reducing sexual guilt, it is nevertheless clear that these professionals believe sexual activity can be an important and positive element in an individual's life. This belief, will, of course, conflict with the belief held by some people that sex should be enjoyed only within the context of marriage or experienced only for procreation. Thus, policymakers and sex educators should realize that some values conveyed in sex education classes are not supported by all members of society.

The fourth group of items focuses upon self-esteem. Although the sex education literature typically refers to self-esteem as a unidimensional quality, phychological research has demonstrated that it is multidimensional and that social, body, and sexual self-esteem, as well as a more general self-esteem, may affect sexual relations. Some sex educators have argued that self-esteem provides an essential motivational component and that without a reasonably high self-esteem, the motivation to prevent an unwanted pregnancy and to build good relationships may be lacking. Moreover, a reasonable sense of self-worth certainly appears necessary when one wishes to be assertive.

The fifth category includes a number of interaction skills whose importance is self-evident; these include decision making, communication, assertiveness, empathy (caring), and conflict resolution skills.

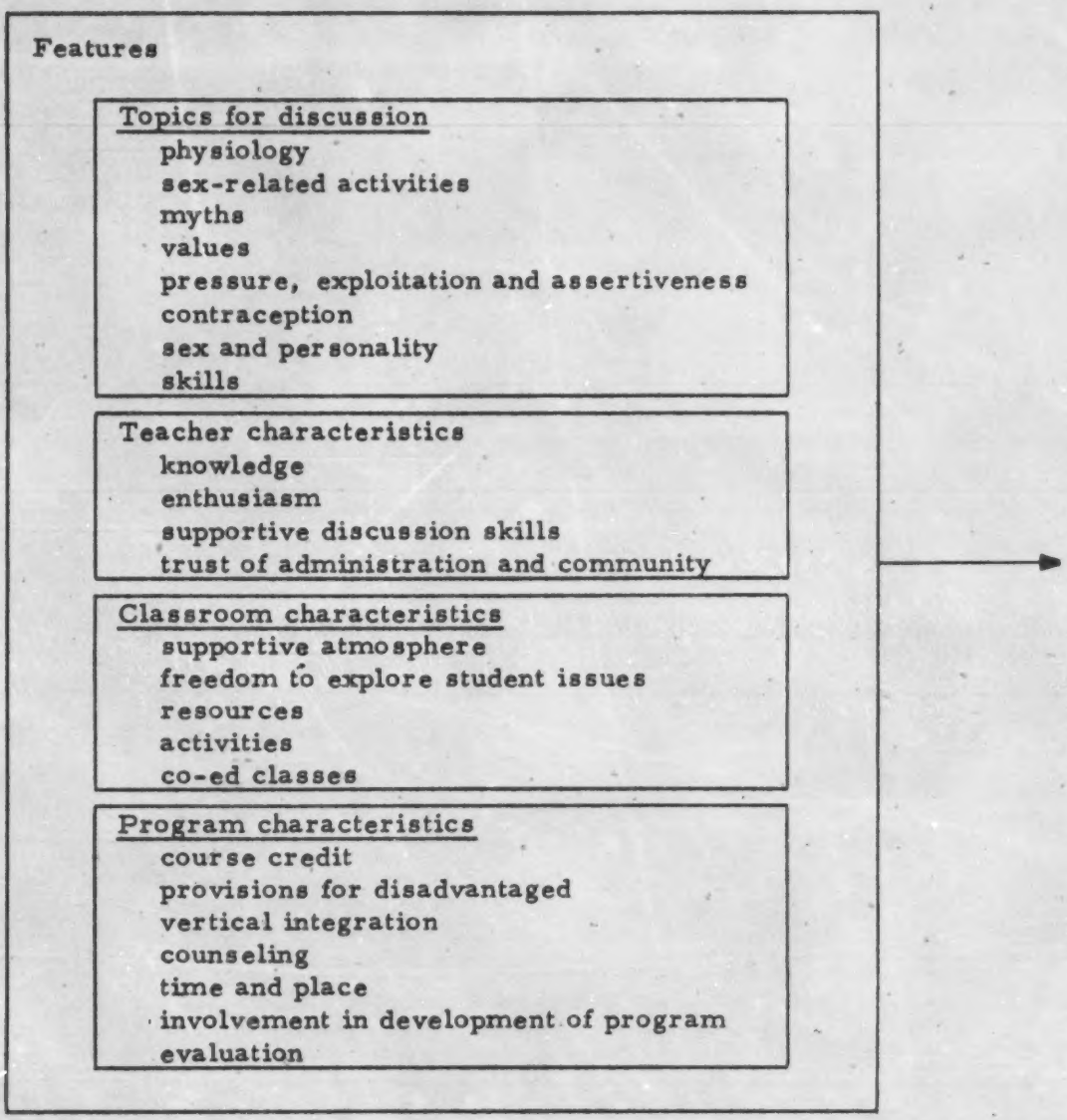
Finally, the sixth group of items recognizes that even if teenagers have the proper values, knowledge, self-esteem, and skills, they may nevertheless have poor relationships with others or become pregnant, if either fear or discomfort prevents them from interacting with members of the opposite sex, engaging in sexual activity consistent with their values, using contraception, seeking help when necessary, or having proper gynecological exams. Adolescents are bombarded with pressure from the media (e.g., movies, books, music, and magazine articles) peers, and their own sexual drives to become sexually active. For some adolescents, fear may prevent sexual intercourse and thereby pregnancy; but, given all the pressures on most adolescents, fear more commonly precludes discussions which would lead to the use of contraception and to behavior necessary for healthy sex lives.

All of these important features and outcomes are summarized in Figure 3-2. It presents the important features, outcomes, and goals, and the causal relationships among them. The arrows represented by solid lines indicate that the specified features have a causal impact upon the outcomes which in turn have an impact upon the goals. The broken arrows going in the reverse direction indicate that achieving the long-term goals may have a subsequent impact upon the participants' knowledge, values, self-esteem, skills, fears, etc.

An Analysis of Subpopulations

Although some scholars have claimed that the sexual practices of different groups of adolescents are converging (e.g., the differences between black and white pregnancy rates is declining), there remains considerable variation in the sexual knowledge, self-esteem, values, skills, behavior, etc. of adolescents. Thus, their needs may differ greatly, and conceivably different programs should have different features for different groups of adolescents. Because the respondents include professionals living and working in different geographic regions, cultures, and programs, we examined the data for the impact of these differences.

In general, the data suggest a uniformity of opinion, not a divergence of opinion based upon location or culture or adolescent group. Approximately half the items have mean ratings greater than 7.5, and on these items there was considerable uniformity of opinion.



* Sex education professionals typically define "sexuality" broadly. When so defined, it refers not to sexual intercourse, but to the broad range of interactions among people. Thus, this goal actually involves the improvement of psychological health and interpersonal relationships.

Figure 3.2

Outcomes

Changes in knowledge
- physical development and human reproduction
- social and sexual aspects of adolescents
- sexual activity
- birth control
- probability of becoming pregnant
- adolescent marriage and parenthood
- venereal disease

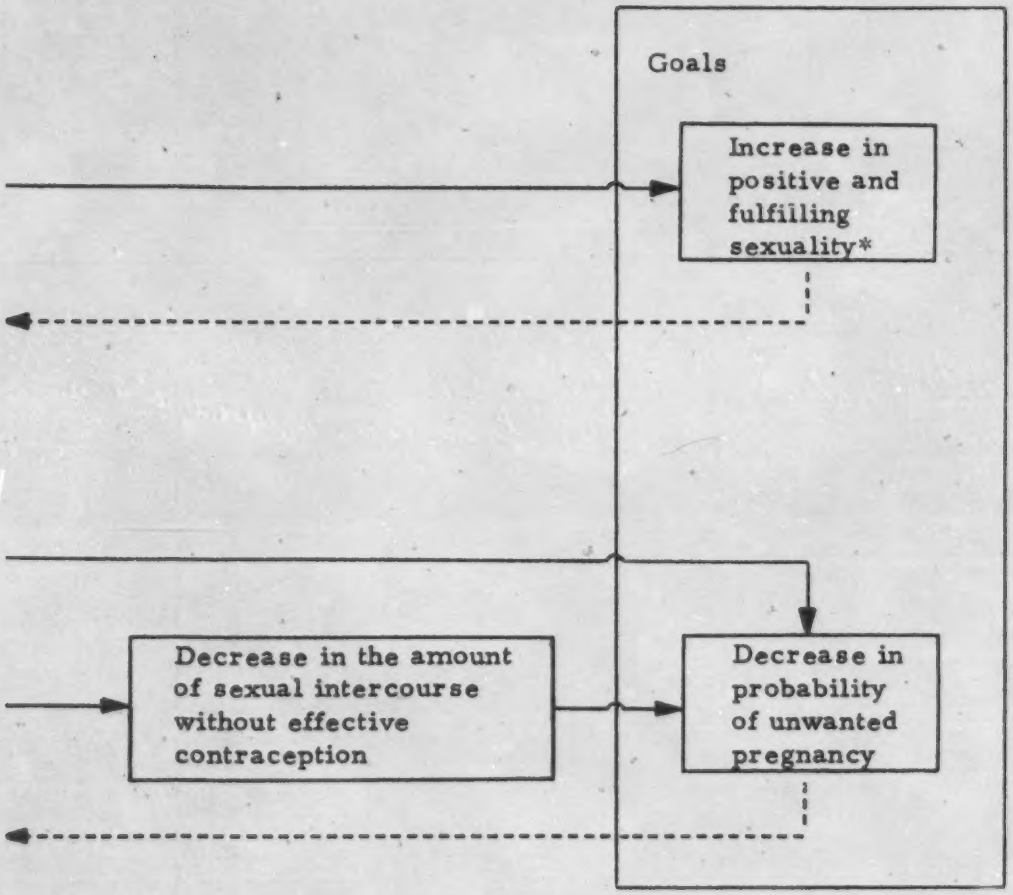
Changes in understanding of self
- goals
- sexual response

Changes in values
- personal responsibility
- body variations
- sex roles
- sexual guilt
- sexual pressure
- birth control
- alternatives to intercourse
- sexual life styles

Changes in self-esteem
- general self-esteem
- social self-esteem

Changes in interaction skills
- decision making
- general communication
- communication of sexual needs
- discussion of sex
- sexual assertiveness
- birth control assertiveness
- caring

Changes in fear of sex-related activities
- heterosexual interaction
- sexual enjoyment
- sexual experimentation
- discussion of sexual problems
- use of birth control
- VD treatment
- gynecological exams
- body functions


Goals
Increase in positive and fulfilling sexuality*
Decrease in the amount of sexual intercourse without effective contraception
Decrease in probability of unwanted pregnancy

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There is, however, the group of items which are rated extremely important by a majority of the experts, but which have more varied ratings. To determine whether a theoretically meaningful structure existed among the rating of these items, we again employed factor analysis. If some groups of experts rated some groups of items as important and other groups of experts rated these items as unimportant, then ratings for these items should be highly related, and should form a factor. Because many of the items were somewhat intercorrelated, factors explaining a substantial portion of the entire variance were formed. However, these factors do not support the idea that particular features are important for particular subpopulations of adolescents for two reasons. First, the items within the major factors include very different types of items. That is, the contents of the items comprising each factor were very dissimilar and did not suggest any correspondence to any particular subpopulations. Second, two factor analyses were performed, one for each criterion, and the major factors of the one analysis were very different from the factors of the other. In sum, the data minimize the importance of subpopulations.

This conclusion should not be overemphasized because of data limitations. It should be realized that sample sizes for both samples is only 50, and that the samples are intentionally not random. Thus, searching for subpopulations of meaningful items or respondents somewhat stretches the integrity of the data, even though many of the correlations on which the factor analysis is based are statistically signfiicant. Moreover, when the experts responded, they may have been considering the needs of adolescents in general, not specific subpopulations of adolescents.

These data are congruent with the discussions with the experts. Several experts emphasized that many features should be adapted to the particular needs of the subpopulation. For example, good listening skills is a quality all teachers should have regardless of population and contraception is a topic that should be covered should be determined by the teacher or the program administrators.

Conclusions

In sum, several conclusions emerge from the data. First, there is remarkable agreement among the experts. This consensus is especially common for those items considered very important, and it occurs just as frequently among items that are considered controversial by the public. Second, the twin goals of reducing pregnancy and improving fulfilling and positive relationships appear not only compatible, but mutually supporting. In the vast majority of cases, an item considered very important for one goal is also considered very important for the other goal. Third, experts clearly believe that discussions of physiology and contraception are insufficient to meet either goal. Instead there should be an emphasis placed upon the changing values, self-esteem, skills, and comfort in sex-related activities. Finally, professionals consistently believe that a successful program should have a supportive and trusting classroom environment in which students share their feelings, beliefs, and experiences.

These conclusions recognize that sex education is very different from many other classes. The purpose of sex education classes is not simply to fill the gaps in the knowledge of adolescents. Instead, sex educators recognize that especially in the area of sexuality teenagers believe incorrect information and myths, and frequently have maladaptive attitudes and behaviors. Thus, the goals of sex education are much more ambitious; they involve the teaching of knowledge and skills, and the changing of these attitudes and behaviors. To do this, programs must be comprehensive and teachers must be unusually sensitive and skillful.

Despite the agreement among the experts, it should be fully realized that these ratings are simply based upon the beliefs of experts, and that these experts may be wrong. Clearly, there is a strong need to verify empirically these judgments. Traditionally, papers end with a call for further research. This time that call is especially valid.

References

Juhasz, A.M., "Characteristics Essential to Teachers in Sex Education", The Journal of School Health, January 1970, v.40, 1: 17-19

Chapter 4:
Exemplary School Programs

Introduction

This chapter identifies and briefly summarizes twenty exemplary school sex education classes or programs. It then describes in greater detail one of them.

Methods

In order to identify twenty exemplary school programs, we completed several steps. First, we telephoned all state departments of education and asked for their recommendations. Second, we wrote letters requesting recommendations to aproximately one hundred organizations and individuals in education and family planning. Third, we carefully reviewed the literature describing programs. Fourth, we discussed exemplary programs with educators at the annual AASECT meetings and other meetings.

These steps generated a lengthy list of potencially exemplary programs. We then telephoned and interviewed each of these programs and used an interview schedule which was based upon the features identified as extremely important by experts (see Chapter 3). Because the list of important features was too specific and also too long for a telephone interview, we focused upon different content areas, the training of the teacher, specific aspects of the course structure, methods of evaluation, and community support.

From the information compiled during these interviews, we selected twenty exemplary programs which are presented and summarized in Table 4-1. We emphasize that these twenty programs are not necessarily the best twenty programs in the country. For several reasons, this table excludes other excellent programs. First, we undoubtedly failed to learn about some excellent programs. Second, we were unable to contact some programs, even though we made repeated attempts. Third, a few excellent programs requested that they not be identified, because subsequent national attention could jeopardize their programs (i.e., local critics might use the national attention to thwart program goals).

Results

Structure of the Courses

Eleven of these exemplary programs are separate courses or units, while fourteen are integrated into other courses, especially health education classes. The sum of these two types of courses exceeds twenty, because some of the programs both integrate material into other classes and offer separate units or courses.

Table 4.1
Selected Features of Exemplary School Programs

Schools	Program Structure					Course T					
	Separate	Integrated	No. of Weeks	Sessions/Week	Staff Training	Emotional and Social Aspects of Sexual Behavior	Human Sexuality As Part of Total Personality	Premarital Sexual Activity	Individual Student's Values	Student's Experiences, Attitudes and Feelings About Sexual Activity	Peer Pressure and Resistance
1. Flagstaff Public Schools Flagstaff, AZ[6]	*		2	5	*	*	*		*	*	*
2. Ferndale Unified School District Ferndale, CA[6]		*	3	5	*	*	*		*	*	*
3. San Francisco Unified District San Francisco, CA	*	*[3]	9	2	*		*	*	*	*[1]	*
4. Jefferson County Schools Lakewood, CO[6]		*	26	1	*	*	*		*	*	*
5. Miss Porter's School Farmington, CT	*		13	3	*	*	*	*	*	*	*
6. Hartford Public Schools Hartford, CT		*	6-9	2-5	*		*	*	*	*[1]	
7. Staples High School Westport, CT	*		9	4	*	*	*	*	*	*[1]	
8. Keokuk Senior High School Keokuk, IA	*		26	5	*	*	*	*	*	*	*
9. Prince George's Schools Upper Marlboro, MD[6]	*		4	5	*	*	*	*	*	*	*
10. Flint Public Schools Flint, MI[6]		*	2	5	*	*	*	*	*	*[1]	*
11. South West High School Kansas City, MO		*	5	5	*	*	*		*	*	*
12. University High School St. Louis, MO	*		18	5	*	*	*	*	*	*	*
13. Charlotte/Mecklenberg Schools Charlotte, NC		*	4	5	*	*	*	*	*	*	*
14. Syosset Public Schools Syosset, Long Island, NY	*	*[4]	10	5	*		*	*	*	*[1]	*
15. Corvallis Schools Corvallis, OR[6]		*	9	5	*		*	*	*	*[1]	*
16. Council Rock High School Newtown, PA[6]	*	*[2]	18-36	3-5	*	*	*	*	*	*	*
17. Oak Ridge City Schools Oak Ridge, TN[6]	*	*[5]	2	5	*	*	*		*	1	
18. George Mason Jr./Sr. High School Falls Church, VA		*	13	5	*	*	*	*	*	*	*
19. Roanoke City Schools Roanoke, VA[6]		*	4	5	*		*	*	*	*	*
20. Rock Springs Schools Rock Springs, WY	*	*[5]	4	5	*	*	*		*		

Key:

* = the program structure has the feature or the topic is a major emphasis

blank = the program does not have the feature or the topic is not emphasized

Topics							Other Program Features		
Advantages and Disadvantages of Different Contraceptive Methods	Effective Use of Different Methods	Masturbation	Homosexuality	Decision Making and Problem Solving Skills	Communication Skills	Special Class Activities for Improving Skills	Community Support	Formal Program Evaluation
*	*			*	*		*	
*	*			*	*	*	*	
*	*	*	*	*	*	*	*	
*	*	*	*	*	*	*	*	
*	*		*	*	*	*	*	
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				*	*	*	*	*
*	*	*	*	*	*	*	*	
	*	*		*	*		*	
*				*			*	*

Footnotes to Table 4.1

1. These schools or school districts cover attitudes and feelings to a great degree, but do not encourage students to share information about their personal sexual experiences.

2. Sex education is integrated in health education in grades 7-10, and offered as a separate course in grades 11 and 12.

3. Sex education is integrated in grades K-12 and lasts three weeks, but a separate course is offered in 10th grade and lasts for nine weeks.

4. Sex education is a separate course in grades K-6, but integrated in health education in grades 7-12.

5. Sex education is a unit in the elementary grades, but integrated in the junior and senior high grades.

6. These schools or school districts all vary the emphasis of particular topics depending on grade level. Except for masturbation, which tends to be covered more in lower grades (junior high), all other topics are covered more thoroughly in the higher grades.

Table 4.2 Persons Interviewed With Exemplary Programs

1. Lorraine Curry
   Flagstaff Public Schools
   701 North Kendrick
   Flagstaff, AZ 86001

2. Patty Berg
   Ferndale Unified School District
   c/o Public Health Department
   529 I Street
   Eureka, CA 95501

3. Joan Haskins
   San Francisco Unified School District
   c/o 502 Boulevard Way
   Piedmont, CA 94614

4. Don Shaw
   Health Education
   Jefferson County School District
   1209 Quail, P.O. Box 15128
   Lakewood, CO 80215

5. Karen Phillips Berry
   Miss Porter's School
   Farmington, CT 06032

6. Louis Bazzano
   Health and Physical Education
   Hartford Public Schools
   249 High Street
   Hartford, CT 06103

7. Dr. Robert Selverstone
   Staples High School
   70 North Avenue
   Westport, CT 06880

8. Jim Vandenberg
   Keokuk Senior High School
   2285 Middle Road
   Keokuk, IA 52632

9. Florence Fenton
   Prince George's County Schools
   3940 Elm Street
   Upper Marlboro, Maryland 20870

10. Dr. George Chamis
    Flint Public Schools
    806 West 6th Avenue
    Flint, MI 48503

11. Pat Tennison
    Home Economics/Family Life
    Board of Education Building
    1211 McGee Street
    Kansas City, MO

12. Martha R. Roper
    University City High School
    c/o 23 JoAnn Place
    St. Louis, MO 63126

13. George Powell
    Health and Physical Education
    Charlotte/Mecklenberg Schools
    P.O. Box 149
    Charlotte, NC 22230

14. Fred DeJong
    Syosset Public Schools
    Pell Lane
    Syosset, Long Island, NY 11791

15. Dr. June McMurdo
    Corvallis School District
    836 N.W. 11th Street
    Corvallis, OR 97330

16. Dr. Konstance McCaffree
    Council Rock High School
    Swamp Road
    Newtown, PA 18940

17. Dr. Bill Burris
    Oak Ridge City Schools
    P.O. Box Q
    Oak Ridge, TN 37830

18. Dr. George Thoms
    George Mason Junior-Senior High
    7124 Leesburg Pike
    Falls Church, VA 22406

19. Kay Duffy
    Health and Physical Education
    Roanoke City Schools
    P.O. Box 13145
    Roanoke, VA 24031

20. Franklin Prevedel
    School District #1
    P.O. Box 1089
    316 B Street
    Rock Springs, WY 82901

The duration of the courses has a remarkably large range; some last only two weeks while others last an entire academic year. The mean length is approximately ten weeks. Similarly, the number of sessions per week ranges widely from one per week to five per week. Significantly, all of the sessions last approximately one hour, undoubtedly so that they can fit into the normal class schedule. This suggests that programs might experiment with class sessions that last a longer period of time or that are more flexible.

Teacher Training

All of the teachers in these programs have had special training in sex education or sexuality, and most of the programs provide or require training opportunities for both the teachers and staff. For example, the Jefferson County School District requires at least twenty hours of preparation in human sexuality. Moreover, many of the teachers teach only sex education and this enables them to specialize. A few of them also offer courses in human sexuality at neighboring colleges.

Content of the Courses

Any course which did not cover most of the topics identified as important was excluded from this list. Thus, it is not surprising that these programs are comprehensive. It should be noted, however, that two of the programs were less comprehensive than the other programs, but they were especially comprehensive given the social and political climates of their communities.

Although the programs cover most of these topics, they emphasize some topics more than others. In order of emphasis they are ranked as follows:

1) human sexuality as an aspect of total personality
2) the individual student's values (tied with above)
3) the advantages and disadvantages of different contraceptive methods
4) methods of improving communication skills (tied with above)
5) the effective use of different contraceptive methods
6) decision-making and problem-solving techniques
7) techniques for resisting peer pressure to have unwanted sexual experiences
8) premarital sexual activity
9) emotional and social aspects of sexual behavior (tied with above)
10) masturbation
11) homosexuality

Although the emphasis placed upon these topics varies, all of the programs covered human sexuality as an aspect of total personality and the individual student's values, and all of the topics are emphasized in at least half of the twenty programs. This demonstrates that in at least some communities, it is possible to cover sensitive and controversial topics.

Community Support

All of these exemplary programs stated that parents and the community strongly supported their programs. In large measure, this support was facilitated by careful preparation and involvement of the community. For

example, the Oak Ridge City Schools provide a period of review for parents to inspect course materials and to meet the teachers. They also have a community advisory board which includes members of several local churches. In the San Francisco Unified School District, the current program evolved from the Project Teen Concern and its well rounded community advisory board.

Several of the programs require parental permission in order for students to participate. In all of these programs less than one percent of the parents refuse this permission. This figure represents strong evidence for the success of the programs and for parental support.

Evaluations of Programs

All the teachers in these programs continually respond to student behavior, student suggestions, and student criticisms, and they thereby continually evaluate and improve their programs. However, only seven of the programs conduct a reasonably thorough and formal evaluation. Several of these use pre and posttests to measure changes in knowledge and attitudes, and two of them asked parents about changes in discussions of sexuality at home. One of them has had an outside research team evaluate it. Most of the remaining programs incorporate only poor evaluations. Nearly all of the programs recognize the need for more rigorous evaluation, and teachers expressed a desire for that evaluation. They expressed an interest especially in the accurate measurement of their program's impact upon their students' behavior. Apparently the evaluations of these programs represent the weakest component of these programs.

Conclusion

The previous chapter identified numerous features of programs that experts rated as extremely important. The nature of those features and the number of those features raised serious questions about the actual feasibility of developing a program which incorporated all those features. For example, it was not clear whether or not it was organizationally and politically possible to develop such a program. The twenty exemplary programs summarized above clearly demonstrate that outstanding programs can be developed and maintained.

University City High School, St. Louis, Missouri

Introduction

The remainder of this chapter describes in greater detail one of the twenty programs summarized above. For several reasons we selected this particular class. First, it appears to be an excellent course and incorporates most of the important features of programs. Second, it thrives, despite the widespread backlash in St. Louis which has attacked other sex education instruction, forced drug stores to remove contraceptives from display, and reduced the effectiveness of various family planning clinics. Third, the teacher, Martha Roper, works effectively with both white and black students, despite considerable racial consciousness in the school. Fourth,

this course has not already been described in the literature.

Despite our selection of this program for more detailed discussion, we are not claiming that this class is the single best program in the country. Obviously, the nineteen programs summarized above and others are also excellent.

Community and School Characteristics

University City and its high school are located in a suburb of St. Louis. Despite both its name and its proximity to Washington University, it is not a college community, and the parents of its student body are not disproportionately academicians. Thus, the community is not atypical in this respect.

In fact, the socioeconomic status of the community is lower-middle to middle class. Ethnically, it is 70 percent white and 30 percent black. It is also 70 percent Christian and 30 percent Jewish. It terms of age, the population is slightly older than the country in general.

In sum, the community does not have obvious characteristics that limit the generalizability of its approach.

University City High School, itself, also resembles many other schools throughout the country. It has 1,400 students, and like many schools, the number of students is gradually declining. In comparison with other schools, University City High probably has a better administration and is more progressive. It also places an unusually large emphasis upon health, broadly defined. For example, health education is required for graduation. (The human sexuality course meets this requirement.)

Program Background

The school first offered sex education in 1945. However, in 1974 Martha Roper introduced and began developing the present more comprehensive separate course on sexuality. In that year, the school hired Roper, and she in turn developed the course because of several school trends: students' grades were continually declining; fights in school and student suspensions were increasing; parental involvement was decreasing; alcohol and marijuana abuse were increasing; interest in health education was decreasing; and sexually transmitted diseases and teenage pregnancies were increasing. Thus, there were a variety of student needs to be met, and from the beginning the course appropriately included various topics other than reproductive biology. At first, Roper presented a series of units on social and emotional health within the traditional basic health class. After these units appeared successful, and after the administrators of curriculum approved them, the units became a separate course.

Unlike the development of some other programs, a special committee composed of school personnel, parents, and other community members was not created. This is partially because the administration is a strong administration, has the support of the community in general, and in turn supports the program. However, there is continual interaction among the

teacher, administration, and community. This interaction is described below.

Philosophy, Goals, and Objectives

Because sexuality is so obviously a sensitive topic, and because different parents have different values about teenage sexual behavior, Roper elucidated several basic principals and goals which she personally could use to guide her instruction and which she could provide to the parents. There are six principles:

1. People deserve respect regardless of their race, sex, class, age, religion, or personal belief.
2. Sexuality is a part of each person's total being.
3. Information about sexuality is important, but not sufficient.
4. Greater clarity about one's sexual ethics leads to behavior which is more consistent with personal standards.
5. Interpersonal communication is a crucial component of healthy sexuality.
6. Sexuality education is an on-going process.

The first principle may be less appropriate for sexuality classes in other schools, but at University City High School where there have been numerous fights and a few racial incidents, and where the student body is so heterogeneous this principle is crucial. It applies both to behavior in general, and to discussions of feelings and attitudes in class. The other principles resemble those found more commonly in other courses.

The goals also guide her instruction and provide information to the parents. They reflect the broader needs of the students:

1. To broaden the students' knowledge of human sexuality.
2. To increase students' ability to set goals and make decisions.
3. To broaden students' understanding and skills in communication and conflict management.
4. To broaden students' ability to create a system of positive personal and interpersonal behavior patterns.

These general goals have been translated into more concrete behavioral objectives for each student. There are four:

1. Students will be able to pass objective tests on sexuality.
2. Students will demonstrate their increased communication skills by using them in class discussions and by writing short assignments.
3. Students will be able to pass tests on the major principles of goal-setting and decision-making and will demonstrate these skills in homework assignments and special projects.
4. Students will be able to write a critical analysis on self-defeating behavior and methods of implementing alternative attitudes and behavior.

These goals and objectives are accomplished through a variety of techniques discussed below.

Course Structure

The physical structure of the room is both motivating and versatile. As expected, the desks are moveable and are frequently put in a circle for class discussions or rearranged in other configurations for other activites. There are also rugs, plants, lamps, etc. to make the room less sterile and more comfortable. On the bulletin boards are numerous news clippings about health and sexuality. These probably have two desired effects. First, they suggest that sexual topics are appropriate topics for discussion and that they can be discussed in a serious manner. Second, they provide information about recent research in these areas.

The present course meets five days a week for an hour each day. It lasts for an entire semester (eighteen weeks). For the course, the students receive a half unit of credit.

Typically, there are about twenty-five students enrolled in each section. As in other courses, this class appears to be more personal and effective when the number of students is smaller. However, when the number of students drops much below twenty, the number of students in various subgroups (e.g., black girls) becomes small, and the members of these groups have greater difficulty expressing their feelings.

Coverage of Topics

The coverage of topics is truly comprehensive. At various times, the class focuses upon the following: nutrition, fitness, stress, rest and relaxation, chemical use and abuse, illness, biological aspects of sexuality, human sexual response and behavior, love and sex, values and morality, sexually transmitted diseases, contraceptive decision-making, teenage pregnancy, abortion, pregnancy and childhood, parenting, making decisions about parenthood, making decisions about marriage, methods of improving marriage, marital dissolution, sex roles, communication skills, group dynamics, family violence, and skills for building a human community. The topics are not covered in this order. The skills are taught first, so that they can be used during the coverage of other topics. Obviously these topics emphasize sexuality, but they cover more than that. Some of the classes of students choose to focus upon additional topics such as men and masculinity, black sexuality, and sexuality of the mentally retarded. Given that the class meets daily for an entire semester, there is sufficient time to focus upon all of these topics and to cover some of them several times for reinforcement. Some of the topics are taught simultaneously. For example, communications skills can be reinforced as they are used in discussions of values and morality.

The course uses three texts: Human Sexuality: A Course for Young Adults by James Leslie McCary, Erroneous Zones by Wayne W. Dyer, and From Now On by Marshal B. Rosenberg.

Teacher Characteristics

Frankly, Roper is an excellent teacher. She received her Master's Degree in Family Life Education at Columbia University, New York, and has subsequently studied at the Institute for Sex Research and the Masters and

Johnson Institute. She has taught at local universities and given numerous presentations on sexuality to local groups and national organizations. This training coupled with her teaching and presentations have encouraged her to learn and organize a great deal of material on human sexuality. They have also given her a fuller understanding of group processes and dynamics.

In the classroom, she portrays an unusual blend of qualities. On the one hand, she is task oriented, professional, and demanding. On the other hand, she is exceptionally open, warm, concerned, empathic, and expressive. These personality traits plus her skills commonly produce an ideal classroom environment.

Classroom Atmosphere and Interaction

Roper uses a variety of teaching and group facilitation techniques in the classroom. Sometimes she lectures; more commonly she facilitates class discussions, role playing, and values clarification exercises.

However, during all of these activites, there is an ideal atmosphere in the classroom that is carefully created. More specifically, there is a very clear normative structure that develops over time. It has two major components. On the one hand, students quickly learn that it is appropriate to ask questions at most any time, to discuss nearly all topics, and to express personal feelings or experiences. Roper encourages this by carefully listening to questions, answering them in a nonjudgmental manner so that the student does not experience a loss of self esteem, comfortably discussing nearly all sexual topics, and serving as a role model. To a much greater extent than most teachers, she expresses her own personal feelings. On the other hand, students are clearly instructed not to ridicule and attack other students. This is the second component. This norm is the responsibility that must accompany the freedom of greater expression. Students are allowed to express disagreements with other students and do so, but there is an emphasis placed upon listening to the other student, respecting that student, and then responding so that there is no loss of esteem.

This normative structure or class atmosphere has clear results; the students perceive the classroom as safe and supportive, and they do in fact describe many of their feelings. This was demonstrated by a verbal exchange between two students. One female student suggested to a male student that he solve the problem with his girlfriend by using some of the techniques learned in class. The male responded with the comment, "You know this classroom is special; we can't do these things out there." Although this suggests that students may have difficulty transferring their skills to the outside world, it also suggests that the students themselves recognize the special process taking place in the classroom.

In classes which emphasize discussion, especially the discussion of feelings and experiences, two problems typically occur: some students do not contribute at all and other more vocal students talk too much. Roper partially, but not completely minimizes the first problem by creating a truly safe environment and rewarding participation. She also partially, but not fully, solves the second problem by continually emphasizing the rights of other students to speak. Frankly, at times many students do talk

simultaneously, but given that most of them are discussing topics relevant to the main theme of the class discussion, this is probably evidence of interest and success, not a problem to be eliminated. Often during these more noisy periods, the students are relating the class discussion to their personal lives, and this is desirable. Of course other times, the conversations are simply wandering and are not productive.

Endless chatter between friends is also reduced by the seating arrangments. On the first day of class, all students are assigned seats alphabetically. Although this reduces extraneous conversations, its primary purpose is to prevent segregation among the races, sexes, and social groups.

Many of the discussions in class are coordinated with specific homework assignments. These assignments distinguish this course from some other sexuality courses and probably make the course more successful. They also enable the course to cover more material thoroughly.

On the other hand, these assignments do produce some disenchantment. At the beginning of the course, some students are disappointed that the course is not simply a rap session, and some of them resent the more academic aspects of the course (e.g., writing papers and taking tests). All of this occurs despite Roper's clear statement on the first day of class that these additional requirements exist.

Handling of Sensitive and Personal Comments or Questions

In Roper's class as in other sexuality classes, several problems can and occasionally do arise when sensitive topics are discussed: some students laugh and giggle in a distracting or derisive manner; students raise unusually sensitive or controversial issues or questions; and students ask intimate and inappropirate questions about the personal lives of the teacher or other students. Roper handles these problems in different ways.

From her past experience, she recognizes those topics which are especially likely to elicit giggling and laughter, and she prefaces the discussion with remarks about appropriate behavior. For example, she comments that the topic is a sensitive topic, that some students will initially feel slightly uncomfortable about discussing the topic and will consequently laugh and giggle, and that it is "ok" to be slightly uncomfortable for a while. This explanation of laughter encourages students to refrain from laughing or making derogatory comments, and it also allows those students who really need to laugh to do so.

When students ask sensitive questions, three problems may arise. First, other students in the classroom may ridicule the student for asking such a sensitive question. Second, the student may be somewhat embarrassed about asking the question and thus may ask the question in a somewhat inappropriate manner. Third, the question itself may be controversial. In response to such questions, Roper uses both body and verbal language to indicate that the question is legitimate and that it deserves a serious answer. Thus, she makes certain that she does not reduce the esteem of the student who asked the question. She then further prefaces her answer by requesting that the students listen carefully to her answer and that they not misquote her. (From

her past experience, she has learned that parents have become most upset at distortions of her statements, not her actual statements.) Finally, she answers the question as fully as possible, giving alternative viewpoints when appropriate.

When students ask questions that are too personal, she reminds them that although she encourages everyone to express feelings, all members of the classroom including herself have the right to refrain from discussing personal feelings and behavior. Because these norms apply to all members of the class equally, they are generally accepted. Sometimes the students ask personal questions, not because they are genuinely interested in the answer, but because they are trying to be funny, or because they are challenging Roper. This more commonly occurs at the beginning of the class when the class rapport and the class norms have not been well established. In these situations, Roper commonly uses humor to defuse the situations, and she also expresses reasons for the inappropriateness of the behavior. The humor prevents the student from experiencing significant loss of esteem, while the explanation of inappropriateness discourages repetition of such comments. Of course, Roper is human: because she experiences a great deal of feeling in the classroom and then expresses much of that feeling, she occasionally responds in a more authoritarian manner to hostile or challenging comments.

Community Relations

Given the backlash against sex education in the midwest and in St. Louis, in particular, the continued existence of the program and the community support is particularly impressive. There are several reasons for this success.

First, parents must sign the registration forms of all students for all courses. Although no special permission is required for this course on sexuality, the parents nevertheless have the option of preventing their children from taking it.

Second, Roper meets with the parents of her students each semester. During this meeting, she describes the course and carefully listens to the parents' concerns. She also uses some of the same skills she teaches in the course.

Third, Roper's presentation of self during these meetings with parents and during other community involvements clearly helps. Because of her background and other professional activities, Roper presents a confident professional image. Significantly, her appearance and general life style are rather conservative, and this is reassuring to the parents. Her involvement in other community events and organizations also helps.

Fourth, the students recognize the vulnerability of sex education courses and adopt a protective attitude. This increases community acceptance. The students also write testimonials in their course evaluations and these are used for support when appropriate.

Fifth and very important, Roper receives the solid support of her administration. The Board of Education, the Superintendent of Schools, the

principal, and the curriculum supervisor all visit the sexuality classes, discuss their contents and dynamics, and provide support. The curriculum supervisor is particularly helpful. As a former University of Chicago graduate student in communications, he can effectively communicate the goals, objectives, topics, and methods of the sexuality course to parents. He responds to phone calls and letters of complaint and holds conferences when necessary.

Evaluation

Each semester the students complete course evaluations. These tend to be very favorable and in the past, some of their suggestions have been incorporated into the course. Moreover, the students appear to learn both knowledge and skills in the course. At the very least, in the classroom, they behave differently at the end of the semester than they do at the beginning.

However, the course has not been systematically evaluated, and there is little solid evidence for the impact upon the students. In particular, there is little evidence that the skills the students appear to learn and utilize in the classroom are transferred outside the classroom. This statement should not be misconstrued. It does not mean that there is evidence that the course is ineffective. It simply states that systematic evidence is lacking. This lack may be one of the major deficiencies of the program. Accordingly, plans are now being made to utilize the questionnaires developed in this contract to better evaluate the program's outcomes.

Conclusion

This program is not selected as the best in the nation, but it is certainly a comprehensive and exemplary program that is staffed with a very capable teacher and both supportive and capable administrators. It demonstrates that most of the features of programs identified by the experts as extremely important can be integrated into a single course. Moreover, the behavior of the students in the course, the skills that they demonstrate in the classroom, and the acceptance of the community all provide evidence of success. Hopefully, improved methods of evaluation will shortly demonstrate that success more forcefully.

Chapter 5:

AN OVERVIEW OF U.S. NONSCHOOL SEX EDUCATION PROGRAMS FOR TEENAGERS

Introduction

Most attention to sex education has focused on schools. In the literature most articles and books have discussed school issues such as values, curriculum, teacher training, teacher qualifications, parental involvement, and community politics. Nonschool programs have been less frequently described. Until recently, reports of nonschool programs appeared most often in newsletters and journals reaching primarily the family planning clinic community. In the last few years, however, concern with teenage pregnancy has stimulated the emerging interest of many other groups in human sexuality education. Religious groups, youth organizations such as girls clubs, local social service agencies, hospital centers, medical schools, and many others are directing educational programs for young people. In addition, a variety of professional organizations are training leaders and facilitators of sex education programs, and other organizations are establishing an increasing number of programs to provide sex education to parents as well as children.

Several recent reports present overviews of varying depth and rigor on nonschool sex education programs (Bogue, 1977; Moore, 1977; Otto, 1978; Scales, 1978, 1979). The unevenness of this previous work is its greatest weakness. Some of the reports discuss the organization of a program and its involvement with the community while others do not; and some describe the content of their programs in considerable detail, while others simply outline them. Some include data on their impact or some form of evaluation, but others do not.

In addition, none of these previous reports has attempted to describe important differences and similarities between school and nonschool programs. For instance, critics of school-based programs argue that community politics cause in-school sex education to be "watered-down," to avoid the issues most useful to the students, and to focus upon "the relentless pursuit of the fallopian tubes" (Gordon, 1975). These criticisms raise several questions. Do nonschool programs cover controversial and important topics to a greater extent than the school program? If so, what features of nonschool programs enable them to do so? Do organizers of nonschool programs adopt different strategies than their school-based counterparts? Alternatively, are they simply less visible?

While organization and content issues are important, the impact and effectiveness of school and nonschool programs also need to be compared. Is there any indication that nonschool programs have a different impact on their target audiences and on their communities than do school programs? Do nonschool and school programs use different methods of evaluating success?

This overview will provide more systematic descriptions of exemplary programs in the U.S. and will partially answer some of the questions being raised.

Selection of Programs

The selection of programs included three steps: 1) the identification of many potentially important programs, 2) the creation of a scheme for categorizing programs by sponsor, and 3) the selection of three to five programs for each category. These steps are described in order.

We first created a list of programs with which we were already familiar. However, to more systematically generate a list of excellent ones, we wrote and telephoned approximately one hundred organizations and programs through the country asking for examples of excellence. These suggestions approximately doubled the number on our initial list. In addition, we reviewed the professional literature for possible additions. (The extensive library and computer searches used to find this literature are discussed in Volume IV with the bibliography.) Significantly, this literature contributed only a handful of additions. Apparently, few journals or even newsletters devote a major emphasis to reporting promising programs.

Table 5-1 is a list of most programs recommended as excellent. Despite our efforts to be comprehensive, this list undoubtedly excludes some excellent programs, and the absence of any program from this list has no implication for its quality.

Table 5-1: Commonly Mentioned or Recommended Programs*

American Academy of Pediatrics
American College of Obstetricians and Gynecologists
American Home Economics Association
Berkeley Health Department
Catholic Alternatives (NYC)
Center for Population and Family Health (NYC)
Chicago Planned Parenthood
Children's Hospital, Los Angeles
CHOICE (Philadelphia)
Cleveland Project on Sexual Learning
Community Mental Health Center of Escambia Co., Inc. (Pensacola, FL)
Community Sex Information, Inc.
The Door
Family Life Institute (Portland, Oregon)
Family Planning Council of Southeastern Pennsylvania
Florence Crittendon Homes (Baltimore)
Florida Department of Health and Rehabilitative Services
Girls' Clubs of America
Georgia Department of Human Resources
Grady Memorial Hospital Family Planning Program (Atlanta)
Harris County (Texas) Health Department
HOME FRONT (Boston)
Institute for Family Research and Education (Syracuse, NY)
James Bowman Associates (Albuquerque)
Johns Hopkins Adolescent Pregnancy Program
Madison Square Boys Clubs (NYC)
National Collaboration for Youth
National Council of Churches
National 4-H Council
National Network of Youth Advisory Boards
National Red Cross
New Futures School (Albuquerque)
New Mexico Family Planning Council
New York University Medical Center
The Open High School (Richmond, VA)
Operation Venus (Philadelphia)
PTA
Peer Education Health Resources (St. Paul, MN)
Planned Parenthood Federation of America
Planned Parenthood League of Massachusetts
Planned Parenthood of New York City
Planned Parenthood of Rochester and Monroe Counties (NY)
Population Institute
Project on Human Sexual Development (Harvard University)
Psychiatric Associates of Tidewater (Norfolk, VA)
Rocky Mountain Planned Parenthood
San Antonio Planned Parenthood
San Francisco General Hospital Adolescent Services Program
Santa Clara County (CA) Health Department, The Males Place
Seattle Planned Parenthood

Sex Information and Education Council of the U.S.
Teen Age Medical Services (Minneapolis, MN)
Temple University Hospital Family Planning Program
Tri-County Health Department (Denver)
Unitarian Universalist Association
United Church of Christ
U.S. Catholic Conference
YWCA — National
YWCA (Springfield, MA)

* This list contains programs that people tended to mention more frequently. It includes many of the best, but undoubtedly it does not include them all.

Moreover, this table intentionally excludes many outstanding programs that are not specifically directed toward sex education for adolescents. For example, it excludes SIECUS and AASECT programs which train professionals and develop materials for parents and others. Similarly, it excludes programs organized by the Parent Teachers Association, March of Dimes, and Girl Scouts which focus more directly upon education for parenthood (Morris, 1977). It also excludes programs which primarily provide clinical services (Brann, et al., 1978).

Our analysis of the included programs indicated that most of them belonged in one of the following eight organizational sponsors:

1. Planned Parenthood Affiliates
2. National Youth Organizations (not church-affiliated), e.g., Girls Clubs, YWCA, Boys Clubs
3. Local Youth Agencies (e.g., The Door)
4. Religious Organizations
5. Adult Organizations with a Concern for Youth, e.g., The Population Institute
6. State and Local Government Departments
7. Programs for Pregnant Teens/Teen Parents
8. Hospital Programs

From the many programs in each category, we selected three to five exemplary ones. In this selection, we used three criteria: 1) the extent to which a program uses a relatively common approach especially effectively, 2) the extent to which the programs use a potentially effective and relatively unique approach, and 3) the ability of the organization to provide us with sufficient information.

Collection and Analysis of Information

From each of the selected programs, we requested information on organization and structure (e.g., audience, duration, involvement of different groups, funding, and types of activities), content (the subjects and topics covered), and evidence for success (e.g., impressions, quantitative data, reports, etc.). In many cases, program staff had to compile this information specifically for our request. In other cases they provided us with existing brochures or copies of proposals used for funding.

This information is discussed in two ways. First, it is codified and presented in Table 5-2 which summarizes the major features of all the programs. Second, each of the twenty-seven programs is discussed in greater detail in the Appendix of this chapter.

Because different programs provided us with different types of information with varying degrees of thoroughness, the entries in Table 5-2 and the summaries in the Appendix are necessarily somewhat subjective. However, efforts were made to make the analysis as accurate as possible. For example, we placed subsequent calls to many programs in order to obtain more detail about particular topics.

Table 5-2 notes simply the presence or absence of a feature in any given

Table 5.2

Prominence of Features in Nonschool Sex Education Programs

FEATURES OF PROGRAMS

Key:

1 = a major component of the program

Blank = not a major component of the program

SPONSORS OF PROGRAMS	Structure: Audience: Individuals	Audience: Small Groups	Audience: Entire Communities	Length of Adolescents' Participation: One-Two Days	Length of Adolescents' Participation: Less Than 3 Months	Length of Adolescents' Participation: More Than 3 Months	Groups Involved in Planning and Organizing: Adolescents	Groups Involved in Planning and Organizing: Parents	Groups Involved in Planning and Organizing: Other Organizations	Groups Involved in Planning and Organizing: Staff Trainings	Funding: Federal	Funding: State	Funding: Local	Funding: Foundations	Funding: Contributions	Activities: Hot Lines	Activities: Small Group Discussions	Activities: Counseling	Activities: Lectures	Activities: Films/a.v.	Activities: Role Playing	Activities: Mass Media	Evaluation: Design: Quasi Experimental	Evaluation: Design: Survey	Evaluation: Duration: Short term	Evaluation: Duration: Long term	Evaluation: Measure: Structured Questions	Evaluation: Measure: Interviews	Evaluation: Measure: Observations	Evaluation: Measure: Vital Statistics	Evaluation: Measure: Frequency Counts	Evaluation: Type: Process	Evaluation: Type: Outcome
I. Planned Parenthood Affiliates																																
1. PP Rochester and Monroe Counties (NY)			1	1		1	1		1		1						1		1		1	1				1			1		1	1	1
2. PP San Antonio (TX)	1	1	1	1	1		1		1	1	1			1			1	1		1		1				1			1		1	1	1
3. PP League of Massachusetts		1	1	1	1		1		1	1					1		1				1			1	1	1	1		1		1	1	1
4. PP Chicago (IL)	1	1	1	1	1				1		1			1	1		1	1	1	1	1	1		1	1		1				1	1	1
II. National Youth Organizations																																	
1. YWCA		1	1		1		1		1				1	1	1		1		1					1	1						1	1	1
2. Girls Clubs of America		1	1		1		1	1	1	1	1		1		1		1												1		1	1	1
3. National 4-H Council	1	1				1		1						1			1		1	1			1	1		1	1		1		1	1	1
III. Local Youth Agencies																																	
1. Teenage Health Consultants, Minneapolis (MN)	1	1	1	1	1		1	1	1	1		1		1	1		1	1	1	1	1	1			1				1		1	1	1
2. Community Sex Information, Inc. (NY)	1	1	1	1	1					1				1	1	1		1	1	1	1				1				1		1	1	
3. CHOICE, Philadelphia (PA)	1		1	1			1	1	1		1					1		1				1		1		1			1		1	1	1
4. Lifestyles (FL)	1	1	1		1		1	1	1		1						1	1	1	1	1		1		1	1	1		1	1	1	1	1
5. The Open School (VA)	1	1	1	1	1	1	1		1				1		1		1	1	1	1	1			1	1	1	1	1	1		1	1	1
6. The Door (NY)	1	1		1	1		1		1	1	1	1		1	1		1	1		1	1			1	1				1		1	1	1
IV. Religious Organizations																																	
1. United Church of Christ		1	1		1	1	1	1	1			1			1		1	1	1										1		1		
2. Unitarian Universalist Assoc.		1				1	1	1	1						1		1	1	1	1	1		1	1		1	1	1	1		1	1	1
3. Catholic Alternatives	1	1	1	1	1		1		1	1				1			1	1		1	1	1			1				1		1	1	1
V. Adult Groups Concerned With Youth																																	

1.	Institute for Family Research		1	1	1	1			1	1	1				1			1		1	1		1		1	1		1		1		1	1	1
2.	Population Institute			1	1			1		1					1	1							1			1						1		1
VI.	State and Local Government Depts.																																			
1.	Georgia State Department of Human Resources		1	1	1	1	1	1	1				1					1		1	1	1	1			1				1		1			
2.	Santa Clara County Health Department (CA)	1	1	1	1	1			1	1			1				1	1	1		1	1	1		1	1			1	1		1			1
3.	Tri-county Health Dept. (CO)		1	1		1		1		1		1	1	1				1	1		1	1					1					1			1
4.	Berkeley Health Dept. (CA)	1	1		1	1		1	1	1				1				1	1								1					1			1
VII.	Programs for Pregnant Teens/ Teen Parents																																			
1.	New Futures School (NM)	1	1	1	1	1	1	1		1		1	1	1				1	1	1	1				1		1				1	1			1
2.	HOME FRONT (MA)	1	1			1	1			1		1			1			1	1	1					1		1			1	1	1			1
VIII.	Hospital Programs																																			
1.	Emory University/Grady Hospital Family Planning Program (CA)	1	1	1	1	1	1	1	1	1		1	1			1		1	1	1	1	1	1		1	1		1	1			1			1
2.	Columbia Presbyterian Hospital/Center for Population and Family Health (NY)	1	1	1	1	1		1		1		1			1			1	1	1		1			1	1	1		1	1	1	1	1	1
3.	University of Pennsylvania Medical School (PA)	1	1			1				1		1			1			1	1	1					1		1	1			1	1	1	1

program. Although we tried to rate degrees of prominence, doing so without carefully developed and pretested guidelines for classification resulted in too much subjectivity.

Findings

Lack of Communication Among Programs

We found that many of these programs were not aware of the others -- communication remains informal and sporadic in most cases. While there has been a proliferation of journals and newsletters devoted to sexuality in the last five years, few devote a primary or even a major emphasis to program reports. Planned Parenthood's newsletter Getting it Together has suspended publication and may cease publication altogether; SIECUS Report may contain one program description per issue; the newsletter of James Bowman Associates (Albuquerque) remains a good source of program data, especially for the Southwest; and many of the journals which publish accounts of programs are burdened with a publication lag which renders much of their material outdated by the time it is printed. Some federal mechanisms which could be used to a greater advantage are the Information Services Bulletin of the National Clearinghouse for Family Planning Information, the newsletter of Project SHARE, and the newsletter of the Child Welfare Resources and Information Exchange (a program of the Children's Bureau in the Administration for Children, Youth, and Families).

Similarities and Differences Among Nonschool Programs

The number of exemplary programs discussed within each category of sponsor is small. Thus, our comments about the similarities and differences among these various programs merely suggest patterns that should be explored more extensively by refined measures.

For all nonschool sponsors, the most common program audience is a small group, although the Planned Parenthood affiliates, local youth agencies, teen parent programs, and hospital programs are also likely to emphasize individuals. Participation in most of these programs is brief. For example, while some involve teenagers in a several month training as peer educators, their contact with the audience is likely to be one-shot or short-term. Only 7 of the 27 programs provide long-term experiences for the audience and most of these are in church-sponsored programs or programs for pregnant adolescents. Given these features, it is not surprising that the most common activities of these programs are small group discussions and counseling. Use of films and other audio-visuals, as well as role playing experiences, are also common.

Most sponsors and most programs (19 of 27) included teenagers in planning and implementation. Similarly 25 of the 27 programs are linked with other community agencies and services. However, only 12 of the programs involve parents. These are predominantly national youth organizations, religious groups, and state and local government departments.

The content of these programs tends to be more similar than different across sponsor types. Nearly all emphasize decision making, communication,

feelings, values, reproductive anatomy, dating relationships, venereal disease, and contraception. Most of them also cover sex roles and various aspects of parenting, with programs for pregnant teenagers more likely to cover the latter. The only topic which is covered by a minority of these programs is abortion information, with the Planned Parenthood affiliates the most likely to include it. We have not presented information about these topics in Table 5-2 because of the great similarity among programs and because simple ratings give a misleading view of actual program content. In the small groups and discussions of most of these programs, content is highly flexible. Sometimes topics are covered, and other times they are not. Thus, content outlines are sometimes misleading and are not comparable across programs.

For their financial support, 16 of these 27 programs depend on multiple sources of funding. Planned Parenthood affiliates, programs for pregnant teens, and hospital programs are particularly likely to receive federal funds, while religious groups and local youth agencies are most likely to depend on contributions. Private foundations contribute to nearly all sponsors, but are most likely to be major supporters of adult groups concerned with youth, local youth agencies, and national youth organizations.

Evaluations, as expected, are based predominantly on simple observations and frequency counts of numbers participating, number of presentations made, etc. Only 3 of the programs (one religious group, one national youth organization, and one local youth agency) are using quasi-experimental designs in their evaluation. Commonly, evaluations tend to be short term rather than long term. Only 5 of the 27 programs (2 hospital, 1 youth agency, and 2 programs for pregnant teens) use vital statistics in their evaluation efforts, and those same programs also use a long-term time frame for the evaluation.

Differences Between School and Nonschool Programs

A fundamental difference between school and nonschool programs is that nonschool programs have greater freedom and flexibility. There are three reasons for this. First, nonschool programs are not constrained by legal requirements or guidelines on course structure, topics, teacher training, student participation, etc. Second, they are not constrained by the school classroom and course structure (e.g., 50 minute classes, meeting five times per week for six weeks). Third, nonschool programs, in contrast to school programs, need not design programs acceptable to all students and to all their parents, and need not be as concerned with the negative reaction of a few community members.

A second fundamental difference is that nonschool programs are more commonly supported by constituents with shared values and principles. This greater cohesion is simply a manifestation of the cohesion of the sponsoring organization's membership.

Partially because of these two fundamental differences, other differences between school and nonschool programs arise. Of particular importance is the much greater diversity of the nonschool programs. They manifest widely different values, incorporate very different structures and types of activities and have very differing goals.

With fewer constraints imposed from the outside, nonschool programs are typically less structured. Undoubtedly the lack of structure is necessary in some cases to maintain adolescent involvement. Obviously students are compelled to attend school where they can choose among classes, but they are typically not pressured to attend nonschool programs unless they are obtaining contraception. That is, the teenagers' participation is more voluntary.

In order to stimulate the interest of young people and to design programs which meet youth needs, many nonschool programs include teenagers in the development and implementation of programs. For example, some nonschool programs train some teenagers as counselors for other adolescents and as teachers of adults who work with youth. In contrast, most school programs are developed and run by adults.

To further maintain teenagers' interest, nonschool programs more commonly discuss topics that concern them and that evoke controversy in some school districts (e.g., values, feelings, premarital sex, and contraception).

Regardless of which topics are considered, schools are more likely to use lecture format. In contrast, nonschool programs more commonly use innovative approaches such as small group discussions, both individual and group counseling, role playing, and various media materials.

Although these differences definitely exist, they should not be exaggerated. Significantly, many of the best school programs include many of the features of the nonschool programs (e.g., group discussions, coverage of feelings, premarital sex, and contraception.

Neither school nor nonschool programs are well evaluated, and both types of programs rely upon anecdotal or impressionistic evidence about particular successes, continued contact, and fewer pregnancies. However, school programs have been better evaluated, partly because there are more of them, partly because their structure facilitates evaluation, and partly because of the interest in school sex education programs.

Once again, this difference should not be exaggerated, for a few nonschool programs have been evaluated. For example, Carton and Carton (1971) evaluated the Unitarian Universalist program titled "About Your Sexuality," and Bleach and Claiborn (1974) analyzed the effectiveness of hot-line counselors.

Conclusions

Several conclusions are suggested by this overview. First, nonschool sex education programs do seem to cover values, decision making, birth control, communication, abortion, masturbation, and homosexuality more than school programs, although the latter two are the least common topics even in nonschool programs. Second, nonschool programs typically are linked extensively with other local agencies, and many include the schools in a cooperative arrangement. Third, evidence of organized opposition to nonschool efforts is quite rare. Fourth, nonschool programs appear to make greater use of mass media approaches, small group discussion and counseling, and experiential activities, such as values clarification, role playing, and

psychodrama, than do school programs. Fifth, teenagers themselves more often contribute to program planning and implementation in nonschool programs than in school programs, frequently being paid and at other times receiving school credit for their nonschool experiences. Sixth, except for a few hospital-based or Planned Parenthood programs, there is little reliable and valid data suggesting that nonschool programs have a different impact on knowledge, attitudes, and behavior than do school programs. Seventh, while the content of nonschool programs tends to differ dramatically from that of school programs, evaluation indicators are often similar (i.e., while the school programs cover "decision making" or "communication skills", nonschool evaluations often test knowledge and attitudes which have not been the primary program emphasis).

These last two conclusions together represent a major result of this research. While the variety of innovative approaches is impressive, the level of evaluation sophistication is not. Except for some of the hospital-based programs and some Planned Parenthood affiliates who track return rates, repeat pregnancy rates and other "hard" statistics, most of the programs reviewed are evaluated casually, and are considered successful by virtue of the enthusiasm of the audience, support of staff, and relative absence of community conflict. Few programs of any kind have attempted to meticulously identify and isolate those factors which are most likely contributing to particular observed effects.

Evaluation is poorly conceived and inadequately funded. There is a need for a series of basic studies, examining programs within each of our 8 sponsor types as a prelude to developing a scheme for evaluating programs which differ significantly in context, audience, and scope. The method and measures discussed in Volume II of the report will hopefully facilitate this. However, evaluating nonschool programs presents a variety of special problems which require some modification of the questionnaires provided. Significantly, the staff of these exemplary projects repeatedly voiced dissatisfaction with their in-house capabilities in evaluation, and frequently requested help in designing better instruments for measuring the features and outcomes of their programs.

Appendix:

Descriptions of Model Programs

I. Planned Parenthood Affiliates

With 185 affiliates around the nation, the Planned Parenthood Federation is the single largest provider of nonschool sex education. In a survey conducted of the affiliates in 1977 and 1978, all of the 104 responding affiliates said they were involved in sex education to some degree (Planned Parenthood, 1978a). About half said they had "comprehensive" programs, and about a third said their sex education was limited to providing biological information or information about birth control. In contrast with schools, a minority of which offer information about birth control and about decision making, almost all the responding affiliates covered these topics. Overall, most of the affiliates do not have objective standards for hiring staff for sex education, nor do more than one-fifth evaluate their programs. In general, sex education itself occupies only five percent of the affiliates' time (Planned Parenthood, 1978b), and occupies from one to thirteen staff members. The staffs include paid sex education professionals, volunteers, and other staff not specifically assigned to sex education (Planned Parenthood, 1978a).

Exemplary programs are plentiful. An adequate treatment of all these programs is beyond the scope of this research, and some outstanding programs are overlooked. Others not discussed are well known for their excellent publications in particular (e.g., Planned Parenthood of Syracuse, and Rocky Mountain Planned Parenthood, Denver). Many others with active excellent programs will not be described due to the necessity of selecting only a few. These include the Planned Parenthoods of Northern New York; Whatcom County, Washington; San Francisco; Santa Cruz; Memphis; Des Moines; St. Louis; Detroit; Dayton; Central Ohio; Pasadena; Washington, D.C.; Seattle; Portland; and others.

1. "Growing Awareness" -- Planned Parenthood of Rochester and Monroe Counties, New York

Beginning in September 1977, PPRMC was awarded a $102,000 grant from the office of Family Planning of HEW through the Genesee Region Family Planning Program to conduct several programs to "combat the rising rate of teenage pregnancies" in Monroe County. Six specific activities were included in the overall project: 1) designing a curriculum package for use in 10 local high schools; 2) producing a planning kit for sex-related teenage services; 3) holding 10 1-2 day workshops on teenage sexuality and pregnancy for health professionals; 4) holding a one-day "high visibility" conference on young men and sexuality; 5) conducting a mass media campaign to attract teenagers, and 6) establishing a hotline.

An Adult Advisory Group helped develop the curriculum and served as advisors to the first three programs. A teenage advisory and reaction group extensively aided the fifth program, and both groups facilitated the conference on male sexuality. The Advisory Group included 56 persons representing a broad spectrum of the community: doctors and nurses, school board members, representatives of religious groups, teachers, minorities, and teenagers themselves.

Although this overview is not concentrating on professional training, two features of the Growing Awareness Project deserve mention. First, one of the 10 professional workshops was held on the needs of Hispanic youth. This workshop was the first of its kind. Previously, Hispanic youth have been forgotten in sexuality programming and are frequently not even enumerated in counts of service need (Martinez, 1979). The drawback of the conference was that only 20 percent of the attendees were Anglo. Many more Anglo professionals would have benefitted from attending. Second, the kit designed to aid professionals in providing sex-related services covers a variety of service settings, not simply comprehensive health centers. It also covers suggestions for all levels of staff.

The male sexuality conference,"M.A.N. '78" ("male adolescent needs") was clearly a visible event as designed. About 170 teenagers attended, 60% of whom were young men. A local disc jockey emceed the event, which included presentations by Family Life Theater of New York Medical College, and by Dr. Sol Gordon of the Institute for Family Research and Education at Syracuse University. In order of popularity, the eight workshops offered at the conference were:

adolescent sexuality
male's role in family planning
dating relationships
decision making in sexuality
sex education in our schools
sexually transmitted diseases
sex and sexism in the media
male liberation

Community response was generally supportive, participant reactions were highly favorable, and news coverage (e.g., The New York Times, Seventeen, and the "CBS Evening News") was widespread. Some unfavorable reactions were recorded, undoubtedly because of preconference publicity and a national campaign against Planned Parenthood.

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2. Planned Parenthood of San Antonio

In spring 1977, Planned Parenthood of San Antonio received a supplemental Title X grant of $35,000 for a nine-month program in peer counseling. In addition, private funds were obtained both to prepare a multi-media presentation on adolescent decision making, and to train peer counselors (including Blacks, Anglos, and Mexican-Americans) to lead rap sessions on sexuality. A local public relations company produced a slide and music show, "Reflections," with the assistance and critiques of the teenage actors. "Reflections" describes love, sex, pregnancy, etc., without using words.

After nine months of production, the show was previewed by youth group leaders, agency directors, and school administrators, and was viewed by several groups of young people, who commented on both technical aspects and the need to show the film in grade school. As the film was being produced, local health, religious, and community service leaders were asked to serve on a Community Advisory Committee. Forty-six eventually served.

One of the Advisory Committee's suggestions was to use the peer counselors in the schools after holding meetings with the high school principals and counselors. In the first year, twelve teenagers between 15-17 years old received about 30 hours of training, scheduled by the peer counselor trainees themselves. Topics covered in the 12 weeks of informal group discussions included: values clarification, human sexuality, reproduction, birth control, abortion and adoption, VD, communication skills, and peer pressure. The students were trained on-campus, with school personnel present, both during and after school.

The counselors have concentrated on outreach. Usually, they show "Reflections," and then lead a rap group sparked by the show. They have made presentations to PTA's, service clubs such as Rotary and Kiwanis, Explorer and Scout Posts, and church youth groups. Their first such program was for a church group, whose advisor was the head of the local Council of Churches. The Council's newsletter for February 1979 contained an article endorsing the media show and the overall sex education program. It is estimated that, between September and December 1978, at least 300 teenagers were directly reached by presentations. Many adults and countless others were reached by extensive newspaper, radio, and TV publicity. Staff members have kept anecdotal records of the "snowball" effect of training -- the informal uses and references to the program which the counselors report making with friends. Especially important is that community support in this predominantly Mexican-American, Catholic community has been highly positive.

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3. Planned Parenthood League of Massachusetts -- Youth Expression Theater

Youth Expression Theater (YET) was started with a $10,000 grant from a group of Boston residents in Spring of 1978. It received another $5,000 in 1979. A half-time sex educator and two consulting theater professionals were hired to coordinate sexuality content and dramatic formats. The theater idea was borrowed from New York Medical College's Family Life Theater, which has reached thousands of teenagers since 1974 with its improvisational series of skits about teenage life. Following the New York model, ten teenage actors were recruited through 1) personal visits to Boston area high schools with strong drama programs, 2) referrals from drama teachers, 3) public service announcements on rock radio stations, and 4) newspaper advertisements. The ten are a mixed ethnic, racial, and socio-economic group.

The group meets twice weekly, for about 3 hours of exercises and rehearsals. Discussions, role playing, presentation of factual information on sexuality, and theater exercises have helped the teenagers identify characters they wish to portray and also to identify critical problem situations they would like to cover. The staff reports that initially, training focused on conflicts with parents, teachers, and other adults, and gradually moved into peer conflicts and sexuality issues. Instead of being concerned with factual information on sex and birth control, the actors have centered on conflicts surrounding relationships, decision making, male and female "images," sex roles, and peer pressure. During the past year, the staff has observed a change in the young actors, from a reluctance to receive information and participate in discussions about sexuality to a willingness to explore personal motivations and to show interest in asking sex-related questions. Some of the ten skits covered in a typical 40-60 minute presentation include the effects of pregnancy on a teenage couple, jealousy and the double standard, interracial dating, a teenager's attempt to tell her mother about sexual behavior, and a young man who is "just a friend." Similar to the Family Life Theater, the actors stay in character after the skits, and the audience asks questions and makes comments about the problem situations they have seen. In addition, most performances also include a small group discussion led by one of the teenage actors, Planned Parenthood staff, and staff of the host agency. Several performances have been held to date for church groups, teen centers, YWCA's, and the general community. In April 1979, YET will perform at a Teen Health Conference for several hundred Boston area high school students, cosponsored by Planned Parenthood, Tufts New England Medical Center, and the Junior League of Boston. YET has also been invited to perform at a state-wide conference of the Future Homemakers of America, which about 400 teenagers are expected to attend. By late spring 1979, YET will have directly reached over 350 teenagers, in addition to the Junior League and FHA conference attendees of several hundred each. Planned Parenthood's already active outreach program provides many other possibilities for the scheduled 18 performances in 1979, including recent work with the juvenile justice programs of the Greater Boston YMCA and the Framingham Task Force on Adolescent Pregnancy and Parenting.

Three levels of evaluation are being conducted. First, changes in knowledge, attitudes, problem-solving ability, and self-esteem of the cast members are being assessed. Second, the performances will be evaluated by all

audiences. Teenage audiences, for example, are asked which problem situation was most relevant, what problems or issues were omitted, etc. Finally, the educational impact of the theater group will be estimated by keeping track of follow-up activities conducted by sponsoring agencies (e.g., new or improved edcational, counseling, or medical services, and changes in program efforts for teens, parents, and professional training).

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4. Chicago Planned Parenthood -- Teen Scene

Chicago Planned Parenthood's program of medical and educational activities is called "Teen Scene." The teen clinic was begun in 1970, and serves about 2,500 teenagers a year. Clients are given a one-hour session on reproductive anatomy, contraception, the pelvic exam, and VD. A group counseling session is then available, lasting for about two hours, in which values, communication, male and female roles, and decision making are emphasized in a nonjudgmental context. Also available are individual counseling and counseling for special groups (e.g., rape victims, post-abortion patients).

Several different outreach programs have been developed. Since 1971, Chicago Planned Parenthood has had a Male Motivation Program which has reached about 22,000 area teenage men, predominantly by going to them, on the streets, in YMCA's, in church youth groups, and in the juvenile justice system. For example, between 1973 and 1976, over 1,000 young "status offenders" were visited for 90-minute sessions in a cooperative effort with the Illinois Departent of Corrections' program of Aid to Youth Development. Each session included a film, a discussion on methods of contraception, and an open-ended discussion on anything related to sexuality and family planning.

Planned Parenthood has continued these efforts, and expanded the approach to reach several thousand teenagers a year with outreach rap sessions, or "outposts." Community agencies such as YMCA's and YWCA's, settlement houses, and church groups have hosted a series of 4-6 week rap sessions with the same group of teenagers. Topics include peer relationships, birth control, VD, sexual responsibility, parenting, drugs, etc. Recreational activities are often available, and nonprescription birth control methods are sold. The outpost program costs an estimated $25,000 per year and is funded by individual contributions and by Planned Parenthood's general funds.

Another outreach effort is a travelling one-act play on "responsible sexual behavior," entitled "That's What It Is." It is funded by the Illinois Family Planning Council through Title X and by private foundations. The play has been presented at schools, YMCA's, churches (Protestant and Catholic), community centers, settlement houses, and even playgrounds in an effort to reach teenagers in their own environment. It takes about 30 minutes, and is followed by a short evaluation questionnaire and a 45-minute rap session. About 60 performances have reached over 4,000 area teenagers at a yearly cost of approximately $30,300. An evaluation questionnaire completed by nearly 800 teenagers (over 70 percent females) indicated the play is well received and that the main message ("sexual responsibility") is understood by teenagers. However, when asked "what did you learn from the play," girls far more frequently say they learned how to use birth control and boys far more frequently say they learned "nothing."

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II. National Youth Organizations

1. YWCA

The National YWCA has for years had an interest in sex education for young people. In 1913, it created a Commission on Sex Education, and in 1939, it published its first book on sex education for adolescents. In recent years, it has lobbied for adolescents' rights to abortions and to family planning services. It has also encouraged adequate sex education for all young people. In 1971 and 1972, the YWCA hosted a series of four 2-day workshops for teenagers and adults to explore the needs of teenage women in the 1970's and to suggest plans of action to meet them. The 118 workshop participants from across the country filled out a questionnaire on their needs. The questionnaire was devised with the assistance of teenagers and then sent to local chapters, which in turn circulated it to the teenage women, some of whom were affiliated with the YWCA.

The project was supported by a variety of sources. Corporations such as General Electric, as well as local businesses in the four workshop cities contributed, as did foundations such as the Ford Foundation, the Charles E. Merrill Trust, the FMC Foundation, and the Louise Roblee McCarthy Foundation.

Sex education emerged on the questionnaire as the second most important need for these teenage women. It followed job training. However, when asked to rank their unmet needs, teenagers, especially Mexican-American teenagers, ranked sex education first.

Recommendations for sex education which grew out of the questionnaire and workshop series included developing sex education for parents, increasing peer counseling, providing more information on the rights of minors to sexual health care services clarifying the relationship between sexuality and human development, working cooperatively with schools, monitoring local programs and services by teens, and establishing model YWCA programs in sex education, especally as a means of giving support to the schools.

The "FAME" program of the Springfield, Massachusetts YWCA is a good example of such a model project. "Family and Maturity Education" is a human sexuality series for teenagers, publicized with the tag-line "it doesn't hurt to know." The series, containing 1-2 hour sessions for six to ten weeks, is provided free to both young men and women in the Springfield area. Begun in 1975, the program has involved about 450 teenagers in the series of discussion groups. Titles of a typical ten week schedule are:

1. Introduction to Sexuality
2. Values Clarification
3. Emotional Aspects
4. Physical Changes in Males and Females
5. Reproduction
6. Incorporating Facts with Feelings
7. Venereal Disease
8. Dating--On Being Responsible
9. Considering Marriage and Parenthood
10. Making Good Decisions

Teenagers are recruited for the series through church youth groups, high schools, neighborhood centers, housing projects, and libraries. Most of them continue as peer educators. In another emulation of the Family Life Theater model, a new project is training about two teenagers from each FAME group to make dramatic presentations on sexuality to adults and to other teenagers. Future plans also call for increased attention to evaluation, which to date has consisted primarily of monitoring the numbers of teenagers participating. The continued work of FAME costs about $20,000 per year, and has been supported by YWCA funds, contributions from foundations such as Boston's Agnes Lindsay Trust, and a $10,000 grant from the Neighbors in Need project of the United Church of Christ.

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2. Girls Clubs of America

Girls Clubs of America has 258 centers in 132 U.S. cities. Over 215,000 girls between the ages of 6 and 18 are members, the great majority of whom come from families with income under $10,000 per year. The centers are typically open 6 days a week, all day on Saturday and in the summer. Three of its major areas of interest are career education, juvenile justice, and human sexuality. These three were the focus of a three-day Wingspread conference held June 1978 with a grant from the Office of Juvenile Justice and Delinquency Prevention, Law Enforcement Assistance Administration. Representatives from Girls Clubs, Boys' Clubs, Camp Fire Girls, foundations, the media, and many other social service agencies produced a series of program recommendations.

In the area of sexuality, these recommendations were the basis for several programs which Girls Clubs identifies as outstanding. These are included in a program manual provided to other Girls Clubs to encourage replication.

The Southside Girls Club in Wichita Falls, Texas, held a nine-session evening program called "For Girls Only," at which local psychologists, cosmetics experts, Welfare Department staff, business people, and doctors led sessions for about 35 girls per session. They covered topics titled, "Who Am I?," "Teenage Relationships," "What You've Always Wanted to Know About Your Body But Were Afraid to Ask," "Birth Control," "Adoption," "Make-up," "Rape and its Prevention," "Women's Role and Identity," and "Job Prospects." Members of Girls Club, girls from Family Court Services, and patients from the State Mental Hospital attended.

Girls Clubs of Wilmington, North Carolina, developed a program called "A Young Woman's Roots," in order to provide about sixty 5th and 6th graders with a chance to address the many questions they had about menstruation, childbirth, and sexuality. Emphasis was on developing decision-making skills, exploring values, learning communication skills, and correcting misinformation related to sexuality. The regional health office provided consultation and staff training for Girls Club staff, and the program's success has led to drawing up a detailed curriculum for use with K-9 grade girls.

Girls Clubs of West Springfield, Massachusetts, developed a program called "Forum," at which teenagers and their parents voted on a series of topics they would like to see covered. "Adjustment counselors" in all the area schools were also asked to vote. Weekly meetings are open to the public. Relatively nonthreatening topics (e.g., changing sex-roles) are discussed during joint sessions of adults and teens; more controversial topics (e.g., family planning) are discussed first with parents, and then with teenagers if they receive parental permission. Among the agencies cooperating in this program are the Alcohol Services of Greater Springfield, the YWCA, Feminist Speakers Bureau, and Family Planning of Western Massachusetts. Future plans include increased school involvement. The funds necessary for the program (transportation and fees of speakers, postage, duplication of material, etc.) are donated by a local Congregational Church.

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3. National 4-H Council

In 1975, the Robert Wood Johnson Foundation awarded a grant to the 4-H Council to support a study of 4-H health programs. The study suggested five areas of program activity for health education, including development of patterns of living that enhance health and increase self esteem, development of self-help skills for prevention of illness and accidents, understanding of community health resources, and understanding human growth and development through the life cycle. In 1977, the foundation awarded a $200,000 two-year grant to help implement these recommendations. On the basis of requests from the State Cooperative Extension Services, Florida and Michigan were selected as pilot sites for projects which began in summer 1978.

The Florida program, called "4-H for LIFE" (Lifestyle Improvement for Everyone) is based on two phases. The first phase is administering a Health Risk Profile to help the 12-18 year old target audience clarify their values about various health issues. The second phase is a several month program of group education and individual counseling sessions. One of the issues covered in this second phase is called "Person to Person," and includes major emphasis on human sexuality, offering information on sexually transmitted disease, contraception, anatomy, and values clarification. One of the four pilot counties is not including anything on human sexuality for fear that the entire 4-H health education program might be caught in a political fight; the other 3 pilot counties are accepting the idea. Teenagers are now taking the profile, and the educational program is planned for late spring 1979. Summer camps and small discussion groups in the fall will provide follow-up opportunities as well. In January 1980, the health risk profile will again be administered to both program participants and a control group as part of the overall program evaluation. About 600 teenagers are expected to participate in the pilot program.

The first session in the second phase is to be held with parents of the participating young people, using the film "A Family Talks About Sex" to lead into a discussion of parent-child communication about sexuality. The young people's sessions will be offered separately to 12-15 year olds and to 16-18 year olds, and will focus on: liking ourselves, dealing with feelings, human reproduction, love, infatuation, friendship, readiness for parenthood (with contraception a part of this session if parents approve), and tough decisions about sex (using the film "Are You Ready for Sex"). Although inner city parents and youth have expressed a willingness to start the program immediately, pilot testing is concentrating first on the two most conservative rural areas in order to estimate the program's general acceptability.

Extensive evaluation is planned. In addition to that mentioned above, parents will be asked to keep a log of their children's initiation of conversation about sexuality, participants will be given a pre and post attitude survey and knowledge quiz, and improvement in role-playing performance will be assessed.

For more information, contact:

Dr. Charles Freeman
Program Leader, Health Education
National 4-H Council
7100 Connecticut Avenue
Washington, D.C. 20015

III. Local Youth Agencies

1. Teenage Health Consultants

In 1973, a consortium of five "free clinics" in the Minneapolis-St. Paul area received funding from the National Free Clinic Consortium to develop a program using teenagers to deliver health care information to other teenagers. Called TeenAge Health Consultants (TAHC), the program was intended to train young people to be both health educators and referral makers for their peer group. When the national funding expired in 1974, the State Alcohol and Drug Authority and the State Department of Health, as well as local foundations, supported the group, now incorporated as Peer Education Health Resources. Groups of ten to twelve teenagers at a time are trained. They frequently receive school credit for both teaching and counseling techniques. Parents are always sent a letter requesting their permission for the teenager's participation, and are typically invited to share a training session about halfway through the eighteen-week training.

Basic content includes: communication skills; problem-solving and decision-making techniques; male and female anatomy; birth control methods; venereal disease; human sexuality; drug use and abuse; nutrition; mental health; and teaching skills. Visits to adolescent health care facilities are typically included. Also typical is a heavy emphasis on role playing--the trainees act out situations involving personal decisions in sexuality, drugs, parent-child relationships, etc., and then the group discusses the implications of particular decisions. Trainees make formal presentations to classes and youth agency workshops and provide individual counseling to other young people. A key aspect of their training is learning about local resources (e.g., doctors and other health professionals), to whom they can refer people with problems too difficult for the trainees to handle. Trainees usually work in male and female teams.

In the last few years, TAHC has trained over 150 teenagers who have reached over 6,500 of their peers in a variety of ways. Among their activities have been establishing an information and referral center in one Minneapolis High School; planning and implementing an all-day workshop on sexuality for other teens, parents, and teachers; and developing a health curriculum for churches, youth groups, group homes, clinics, Girl Scouts, and YWCA.

A yearly budget for a TAHC program in five rural Minnesota counties costs roughly $20,000 and is funded by the State. These teenagers have even made presentations to local Kiwanis and Rotary Clubs to increase awareness of sexuality and other important issues in adolescent development. A recent development is the "mini-TAHC" training, encompassing about 30 of the usual 60 hours. Staffers consider this to be as successful as the more lengthy training and one of the groups' current activities is producing a weekly radio show run by and for teenagers called TIPS, "Teen Information Program and Service." (See Scales, 1979, for more.)

For more information, contact:

Sandra L. Valle
Executive Director
Peer Education Health Resources
1600 Portland Avenue
St. Paul, Minnesota 55104

2. Community Sex Information, Inc.

Community Sex Information, Inc. was founded in New York City in 1971. Its budget of about $25,000 per year is met through individual contributions, small foundation grants, and its own fund raising affairs. Space and phones are donated by Planned Parenthood of New York City.

While it has expanded its programs in recent years to include providing speakers on sexuality, supplying consultation on establishing sexuality services, and offering training to a variety of professionals, its main activity has been a very successful hot line. Hot lines have been highly successful in all areas of the country. For example, one recently established by Virginia's Bureau of Family Planning reports receiving over 3,000 calls in its first ten days (Calos, 1978). National Operation Venus was another highly successful hot line begun in 1970 with the help of the Archdiocese of Philadelphia's Department of Youth Activities. It received over 54,000 calls from around the country in 1978. CSI's rate of somewhat more than 1,000 calls a month is more typical. Twenty-five volunteer adults staff phones from 6 p.m. - 8 p.m. each evening, using the studios of a cooperating radio station (WMCA). The telephone counselors are between 22 and 64 years old. The staff believes teenagers have not become counselors because of the enormous time commitment involved in training (at least 200 hours plus supervision.) Although most of the callers are currently between eighteen and thirty-five, CSI reports the number of young callers is increasing rapidly. They note, however, that the 6 p.m. - 8 p.m. hours may well be a deterrent: When CSI held an all-day marathon to receive calls, as well as when it appeared from 2 p.m. - 5 p.m. on a public television show, the percentage of teenage callers jumped to between thirty and forty percent. About three-fourths of the callers are men, and more than 80 percent say they have never talked to anyone else about their question or problem. Almost all of the callers want to know whether they are "normal."

The twenty-five staffers are given a several month training in cognitive, affective, and skills components, and are expected to staff phones for one year after training. In addition to readings and presentations on sexual anatomy, psychology, and values, the trainees see explicit films and listen to audiotapes of people describing a variety of sexual life styles. They then use small group discussion to process feelings about what they have just seen or heard. Finally, training and supervision in counseling and specialized telephone techniques are provided, with extensive use of role playing, in an effort to hone skills in nonjudgmental listening, values clarification, and providing assistance in decision making.

Most of the callers are interested in the following types of information: pregnancy, contraception, venereal disease, menstruation, menopause, sexual dissatisfaction, premature ejaculation, oral sex, masturbation, penis size, homosexuality, and interpersonal conflicts.

For more information, contact:

Dr. Michael A. Carrera
President
Community Sex Information, Inc.
P.O. Box 2858
Grand Central Station
New York, New York 10017

3. The Open High School

Richmond, Virginia's Open High School was opened in 1972 at the request of parents. It is included in this review because the "school" serves merely as a "home base" for the activities of the 165 students--the learning laboratory is the community. Students plan their own curriculum, help evaluate their progress, and use the flexible schedule of the open school for independent study, volunteer work, internships at universities, social agencies, business and churches, and paying jobs. Students are fourteen to nineteen years old and are at grade levels 9-12. They include both potential dropouts and high achievers. It is funded largely by the public school system, but most of the teachers are volunteers and many of the supplies are donated by the teachers, the students, and cooperating community agencies.

The sexuality component was not a coordinated effort until 1975. It began with a one-semester course entitled "Everything You've Always Wanted to Know About Sex That Wasn't Written on the Bathroom Wall." It is now called "Sexuality and Self." Although individuals work out their own programs in sexuality education, the general issues covered are male and female anatomy, pschological aspects of sexuality such as self-esteem and feelings, and social aspects such as cultural values and laws. In addition, communication skills and decision making, as well as self-discovery, are emphasized. The course meets once a week for two hours, and runs for eighteen or thirty-six weeks according to the commitment of the students. Small group discussions, films, relaxation techniques, fantasy exercises, and role playing are integral parts of the course. Each student is also encouraged to develop internships with community agencies, some of which have included Zero Population Growth, Planned Parenthood, ERA Lobbyists, Richmond Health Department clinics, and Southern Women's Project of the American Civil Liberties Union.

The teachers are at times full participants, sharing their own values and points of view, and at other times they play the more traditional role of providing information. In order to involve students emotionally in learning, simulations of real-life situations are the most frequent activity used. These have included the "chick project," in which each student accepted responsibility for the actual developing egg, and which prompted discussions of child abuse, miscarriages, abortions, post-partum depression, and fear of parenthood. Another simulation was "The Trade-off," in which the females in the class "gave away" to the males a uniquely female experience. The young men were brought to a Planned Parenthood clinic, where they had to go through a pelvic exam. They removed their shirts and socks, and had to get into the stirrups. The young men were brought there without knowing why, left in the waiting room for half an hour, the doctors asked the same questions "over and over again," and the girls walked in and out of the room during the "pelvic." Subsequently, the young men made up an elaborate "Dating Game," in which the girls had to pursue them for dates, experiencing rejection fears, being stood up, etc. Both sexes reported a greater awareness of and respect for the positions of the other sex.

Students evaluate every class session by writing a letter to the teacher. At the semester's conclusion, they write a comprehensive evaluation and include suggestions for improvement. Parent and community response has been very positive. The school administration and other community agencies have asked for the Open School's advice in planning similar programs, and several parents have commented on their child's growth as an apparent result of participating in the class and community experiences.

Some members of the staff feel that not enough young men have been involved and that other staff members do not view the sexuality experiences as an essential part of the curriculum.

For more information, contact:

Evonne H. Reed
Open High School
203 A.E. Franklin Street
Richmond, Virginia 23219

4. Life Styles

Life Styles was begun in 1977 as a pilot project in response to increasing numbers of teenage pregnancies in a Florida health district. The Florida Department of Health and Rehabilitative Services contacted the Community Mental Health Center in Pensacola with a request to design and implement an educational and counseling program. Although the first field tests of the resulting approach received a favorable response, the staff decided that the original approach was too narrowly limited to adolescent pregnancy, and thus redesigned Life Styles to its current form. It is a twelve session curriculum providing the basis for a series of discussion groups held at youth centers, detention homes, YWCA's, church groups, Boys' Clubs, Salvation Army posts, schools (at the request of individual teachers), and elsewhere. Rather than being limited to teenage pregnancy, the curriculum is broadly based on Havighurst's developmental tasks of adolescence. The sessions include values clarification, adolescent changes and behavior, influences on sexuality, decision-making, exploring relationships, child development, love and marriage, adolescent pregnancy, the costs of early parenthood, and making future plans. The emphasis throughout is enhancing self-esteem, cultivating communication skills, and assisting in the ability to make decisions. From an early level of twenty such groups offered per month, the six staff members (devoting about eighty percent of their time to Life Styles) now offer roughly 120 groups per month, with two leading each group. In FY 1978-1979, $93,000 was allotted to Life Styles from Florida's Title XX funding. During the first six months of that year, 4,500 teenagers participated in Life Styles, roughly a 50 percent increase over the first year. (The budget was also increased about 50 percent.)

Teenagers have contributed significantly throughout the development of Life Styles. They've commented on the curriculum, designed artwork and materials for the project and developed spinoff projects. For example, after a Life Styles presentation at a local Black service club, the club members developed a series of open-ended skits dealing with teenage concerns, which the twenty-two members now present to local junior and senior high schools. Parents are also actively involved. Before their child participates in a program, parents are encouraged to attend an orientation session to familiarize themselves with the program content. They often receive programs similar in content to those for the teenagers. All of the programs employ didactic sessions, experiential exercises, role playing, and individual counseling.

Evaluation is being conducted with several measures. Pre and post knowledge and attitude instruments are being developed by the staff, referrals to local agencies arising from participation will be measured, and changes in pregnancy rates in the surrounding area will be analyzed.

For more information, contact:

Pamela A. Sofferin, M.S.
Director of Education and Presentation
Services
Community Mental Health Center
1201 W. Hernandez Street
Pensacola, Florida 32501

5. CHOICE, Philadelphia

CHOICE (Concern for Health Options: Information, Care, and Education) is funded by the Pennsylvania Department of Health, through the Family Planning Council of Southeastern Pennsylvania (the annual budget of roughly $88,000 is currently funded through Title V). Prior to 1975, it specialized in problem pregnancy counseling, but in 1975 it began a family planning hot line to provide preventive counseling. Over 10,000 calls were received between July 1977 and June 1978. Most of the calls concerned adults, but as outreach efforts intensified over the year, the percentage of calls about teenagers jumped from 10 to 27 percent. A third of the calls about teenagers were made by relatives or friends and not teens themselves. Only five percent of the calls were about men. The first quarter of 1978-1979 showed an overall twelve percent jump in the number of calls, as well as a 289 percent increase in the percentage of calls about teenagers. In addition, more teenagers are calling for themselves and the percentage of calls generated by outreach efforts has more than doubled.

The outreach efforts of CHOICE are varied and particularly important. Calls generated by these efforts tend to be more concerned with preventative information than with crisis intervention. Forty percent of teens' calls are due to outreach efforts. CHOICE utilizes the media extensively, and the evaluation shows that calls due to media announcements far outnumber those generated by speaking engagements, brochures, or posters. CHOICE has a twelve person Teen Advisory Committee composed of adults and a twelve person Teen Auxiliary Committee composed of teenagers, some of whom are paid. These committees advise and help devise scripts and graphics for advertising. They have a thirty second TV spot running on six area stations, as well as ten and twenty second public service announcements on ten of the most popular teen audience radio stations. Last March, eight radio stations aired the spots developed by the Population Institute's Rock Project, prompting a marked increase in the number of hot line calls. The teenagers have recently designed and acted in a new TV spot, taking place in a pinball arcade. In addition, 400 "car cards" were distributed and placed on busses, trolleys, and subways. They generated a noticeable increase in calls. Advertisements have been placed in nineteen high school newspapers, and a similar advertisement appears in the Yellow Pages under "birth control." Finally, about 40,000 pieces of literature have been distributed to school nurses, school counselors, family planning agencies, hospitals, teen service agencies, community centers, and gynecologists in the Philadelphia area.

A parents' brochure explaining the hot line and the need for its services was produced and over 700 distributed to home and school association presidents, attendance supervisors, school counselors and others. It emphasized that the service is not intended to replace the home, but, is intended for both teenagers and parents to use when they have questions. CHOICE's other outreach activities include numerous speaking engagements to schools, churches, colleges, and many others. In addition, they held a Community Leaders Brainstorming Session to generate suggestions for improving outreach efforts. One suggestion included the distribution of literature in employment and job centers, housing projects, skating rinks, fast food chains, etc.

CHOICE has also produced a booklet called CHANGES--You and Your Body which covers basic information on sexuality and reproduction. It includes an easily used directory of local services, written at roughly a ninth grade reading level. A national version of the booklet may be produced.

For more information, contact:

M. Ann Ricksecker
Hot Line Coordinator
CHOICE
1501 Cherry Street
Philadelphia, Pennsylvania 19102

6. The Door, A Center for Alternatives, New York City

Another local youth agency given extensive coverage is The Door - A Center for Alternatives. In operation in New York City since 1972, and funded largely by Title X, at more than a million dollars per year, it offers a single-site comprehensive array of services, everything from nutrition counseling to woodcrafting classes. The Door provides free birth control to anyone, regardless of age, but its overall aims encompass more than mere provision of services. The program is based on the belief that teenage pregnancies and sex-related problems are often the result of nonsexual concerns, such as self-worth and lack of job skills. Thus, the primary effort of The Door is to provide an atmosphere of trust and self-discovery for young people. Parental permission for services is not required, and the young person's confidentiality is guaranteed. These are seen as two of the key components for building trust. In addition, there are numerous opportunities for teenagers to learn skills and pursue interests at the single site. Photography, sewing and weaving, dance, gymnastics, and videotape equipment are all available. On most evenings, there is music and dancing. There are also many services provided in addition to sex-related care. These include legal aid, mental health services, vocational resources and counseling, nutrition education, and others.

About 2,600 different teenagers are seen each month, and about one-fourth receive some sexuality services or education. Roughly equal numbers of males and females are served. Unlike many centers, The Door is open until 11 p.m., thereby allowing many teenagers who have unusual schedules to attend. The multifaceted nature of The Door allows for a variety of entry points into the sex-related services. For example, a teenager may initially arrive seeking legal aid or drug counseling, might return to use the gym facilities or some of the creative arts programs, and may after several visits become sufficiently accepting of the staff to participate in a sexuality rap session or inquire about birth control. Thus, far more than one-fourth of the teenagers will eventually receive some sex-related services.

Its Family Planning Counseling Service is staffed by four paid and twenty-two volunteer students, the latter being primarily graduate students. Extensive training prepares them to provide contraceptive and medical services, pregnancy evaluation, post-abortion counseling, and short-term sexuality discussion groups. These groups use trigger films and values clarification exercises to raise issues related to sexual roles, identity, and values. "Health Tables" in the Learning Center are set up by staff to show films, explore contraceptive devices, and conduct other health education activities. A detailed description of The Door appears in Moore, 1977.

For more information, contact:

Bruce Armstrong
Family Planning Coordinator
The Door - A Center of Alternatives
618 Avenue of the Americas
New York, New York 10011

Another interesting program is being conducted by Dr. Michael Carrera in New York. It is a multi-dimensional program in staff training and is conducted for about fifteen to twenty weeks, three hours per week, in the Grahm Home for Children, Children's Village, and the Pleasantville Cottage School. The aim is to sensitize the staff to the sexuality needs of their young residents and to prepare them to develop six week and ultimately twelve week programs. In these programs the staff meets with eight to fourteen year olds for one and a half hours per week. Carrera (1978) has reported that program participants increased their sexual knowledge and changed their attitudes in some areas. For example,they expressed an increased willingness to assume responsibility for birth control, an increased tolerance of various sexual behaviors, and an increased responsibility for non-marital intercourse.

IV. Religious Organizations

1. United Church of Christ

The United Church of Christ is affiliated with the umbrella organization of the National Council of Churches. The UCC has been actively involved in human sexuality education for some time. A special spring 1978 issue of their Journal of Current Social Issues was devoted to sexuality, and they are currently involved in the "Neighbors in Need" (NIN) Teenage Pregnancy Project. Started in October 1977, the project is intended 1) to help provide financial support to direct services for teenagers in the area of pregnancy prevention and 2) to assist in identifying needs and developing educational resources to meet them and 3) to build an on-going network of support within the church for concerns of family planning. In all cases, a holistic approach is taken (i.e., sexuality education is placed in the broader perspective of overall adolescent development and family and community impact).

The first aim is being met by awarding grants (under $10,000) to various small groups around the country. Some of the agencies provide services for pregnant teens or teen parents and their infants, while others focus more on youth who are not pregnant. For example, $10,000 has been awarded to Casa Central in Chicago. Casa Central is an inner-city Hispanic Community outreach center with substantial services for youth. It includes a half-way house for runaway and homeless youth. With the help of a NIN Grant they have hired a community outreach worker who will develop educational programs in responsible sexuality. This person will be particularly concerned with 1) helping a teenager who is pregnant, 2) providing access to counseling and information about contraception, and 3) developing more awareness among teenagers in the broader community. The program is endorsed by and involved with an ecumenical group of Hispanic churches in their community, the United Way, and Planned Parenthood. Concurrent and continuing financial assistance are anticipated through the Illinois State Government.

Another program funded by the United Church of Christ is the Philadelphia Men's Resource Center. This young institution was organized by two men experienced in the field of human sexuality counseling and education. Through their NIN Grant of $4,350, they will present and evaluate an innovative program of father and son weekend workshops with the goal of assisting and encouraging male teenagers to make responsible sexual decisions. They believe these programs will enhance the father and son relationship so the two may speak openly about issues such as contraception and sex roles. The grant is for half their request. After the first half of their project is completed and an evaluation is submitted, the UCC staff group will consider funding the second half of their proposal.

A survey of sexuality issues, asking for suggestions and attempting to determine need, was sent to United Church of Christ youth workers and ministers. The results are currently being analyzed, and in conjunction with a review of any materials developed under the grant program, will form the nucleus of the UCC response in the area of resources. Two other grants will be awarded to UCC Conferences, the South Central and the Washington/North Idaho Conference, to train one adult and one young person from each of sixteen congregations, who will then offer separate sexuality programs for adults and

youth. In addition, the NIN Project has been assisting the Population Institute in its three-city pilot project (Cleveland, Des Moines, and Seattle) to expand sexuality education in cooperation with youth-serving agencies (see Senderowitz, 1978 and Scales, 1979 for details). Finally, the project staff have been involved in developing for late spring 1979 publication a special edition of YOUTH magazine. Teenage pregnancy and sexuality will be among the primary topics covered in the issue, which is expected to reach more tha 40,000 teenagers across the country.

For more information, contact:

Bill Stackhouse
Teenage Pregnancy Project Associate
United Church Board for Homeland Ministries
287 Park Avenue South
New York, New York 10010

2. Unitarian Universalist Association

UUA developed the multi-media curriculum "About Your Sexuality" in 1971. Designed principally for younger adolescents between the ages of twelve and fourteen, the program has also been used extensively with older teenagers and with adults. A team of sex educators, clergy, psychiatrists and others worked for over a year in developing the program, which was pretested in 25 different UUA churches with the cooperation of over 500 teenagers, parents, and teachers. The program has been revised twice since then.

The program is designed to create an open atmosphere in which questions may be raised and feelings expressed about issues which are usually not treated in school programs. Thus, detailed instructional booklets are provided on the subjects of masturbation, "making out," making love, homosexual life styles, as well as on birth control, venereal disease, feminity and masculinity, male and female anatomy, same-sex relationships, conception and childbirth. Numerous teaching aids are provided in the package and are keyed to the subject areas, with detailed suggestions for their use. Filmstrips, recordings, photographs, and student activity sheets are included. For example, one filmstrip, entitled "Breaking the Language Barrier," is used to help both students and teachers become comfortable with slang and technical terms in sexuality. Some of the recordings present a range of young people's reflections on their first love making experience, both positive and negative, while other recordings contain interviews of homosexuals describing their life style and experiences. Although there is sufficient material for thirty to forty, one and one-half hour sessions, students decide in the first session what topics they wish to discuss and in what order.

The package is designed for use in small discussion groups of about eight to twelve people, and is intended to be implemented by a male and female leader team. Parents are always asked for their permission for a child to participate. The sessions are typically held in church facilities. Other religious groups, Planned Parenthoods, colleges, and a variety of social service agencies have also used the program. In addition, UUA reports that a large number of private schools use it, but that is has had a very limited use in the public schools.

Two evaluation studies have been conducted. One (Carton and Carton, 1971) is based on a very small sample (less than ten students) and thus will not be discussed. The other was reported in a series of articles in UU World in spring 1974. About 800 young people between twelve and fourteen years old filled out a "research questionnaire," both before and after the program. Another group of about 400 twelve to fourteen year olds who did not take the program also filled out pre and post questionnaires. Responses indicated that those who took the program 1) became less "confused" about 13 topic areas, 2) more frequently discussed the topics with parents, friends and others, and 3) became more tolerant of variation in sexual expression. The most significant increase in communication occurred with members of the immediate family, particularly the father. Communication with mothers was sometimes high before the course and remained so. Those taking the course for less than five months grew more tolerant of sexual variation as much as those taking it for more than five months, but students taking the course for a longer period had greater understanding of the topics and reported more communication. Girls

showed greater change than boys. For example, the junior high girls were the most confused group at the beginning, but by the end of the program, they showed the greatest improvement in understanding.

For more information, contact:

Hugo J. Hollerorth
Curriculum Director
Unitarian Universalist Association
25 Beacon Street
Boston, Massachusetts 02108

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3. Catholic Alternatives, New York City

Catholic Alternatives was begun in 1976 as a counseling center on sexuality. It assists people in their decision making by providing counseling and educational services covering a variety of issues, from birth control and the decision to have sex, to VD, abortion, and sterilization. It has been funded for about $100,000 each year by a variety of foundations, especially Sunnen, Noyes, Hazen, and the General Service Foundation.

Outreach to teenagers is one of Catholic Alternative's primary missions. Each summer, they offer a series of Sexual Responsibility Workshops for teenagers. Fourteen were held in 1977 and twenty in 1978, and they reached about twenty-five teenagers per session. The sessions are led by staff who are trained at the Margaret Sanger Institute and young people in their intern program. The sessions are held at a variety of community agencies, such as the Girls' Club of East Harlem, South Bronx Community Center, Lower West Side Youth Council, and others. Since nearly thirty percent of public school students in New York are Puerto Rican or of other Hispanic heritage, a major emphasis is on delivering services to Hispanic youth. With this goal in mind, they hired an Hispanic Program Director, train several Hispanic teen interns each year and provide all materials, counseling services, and other contacts in both English and Spanish.

Topics covered at the teen workshops include: teenage relationships with parents and each other, physiology, teen parenting, pregnancy prevention, adoption and abortion, and venereal disease. Several of the topics are presented with videotapes produced by the teen interns of Catholic Alternatives, and role playing is used extensively, especially in the presentation of adoption and abortion.

At the beginning of each fall semester, job counselors at about twelve Catholic and public schools are approached with a "help wanted" flyer and are asked to publicize the availability of teen internships. Candidates are then interviewed by the staff and selected on the basis of genuine interest as well as residency, race, and sex. In 1978, forty-two candidates were interviewed for the six available positions. The jobs pay $2.50 per hour for about eight hours each week. The interns receive an intensive two-week training based on the material presented in the Sexual Responsibility Workshops, including videotaping and feedback on their role playing and presentation techniques. The interns design the graphics and write the copy for all primary advertising for the teen program. They distribute flyers and literature in their neighborhoods and at gathering places for teenagers, such as Puerto Rican Day Parade, discos, the Paladium (rock shows), Madison Square Garden, and Central Park. In addition, they research community youth centers and groups in their neighborhoods and make the contacts which lead to workshop presentations at those centers. The staff's aggressive promotion of the workshops has resulted in a variety of atypical sponsors for this kind of sex education. A presentation last year for sixty Directors and staff members of New York Housing Authority Community Centers resulted in requests for fifty-five Sexual Responsibility Workshops for teens to be given between January and June 1979.

In the past year, the 1978 group of interns produced two videotapes. They both wrote the material and acted in them as well. "Disco" examines a

couple experiencing an unplanned, teenage pregnancy, and "The Game" examines jealousy in teenage relationships. Both of these are used extensively in the workshops and presentations. In addition, the teenagers produce a monthly newsletter called "What is It?". It contains articles and information on sexuality, comic strips, and questions and answers. Catholic Alternatives estimates that several thousand teenagers have been directly reached through their efforts.

For more information, contact:

Joan Harriman
President
Catholic Alternatives
30 East 23rd Street
New York, New York 10010

Activities of the U.S. Catholic Church are not described as models here because they take place primarily within the parochial schools in the 161 dioceses across the country. According to the National Catholic Education Association, there are over 850,000 grade 9-12 students in U.S. parochial schools, and as many as half may be receiving organized sex education based on the Benziger Family Life curriculum, according to testimony before the House Select Committee on Population. (See Scales, 1979 for details on the curriculum.) In addition, several religious groups such as the American Lutheran Church and the umbrella group of many denominations, the National Council of Churches, have taken leading roles in calling for sexuality education and developing standards and approaches for such efforts within their denominations. However, little data is available on the extent and kinds of programs aimed specifically at young people. (See Gordon, Scales, and Everly, 1979, and Smith, 1978 for details on the efforts of religious groups.)

V. Adult Groups with a Concern for Youth

1. The Institute for Family Research and Education--National Family Sex Education Week

The Institute for Family Research and Education at Syracuse University was established in 1970 to strengthen parent-child communication in sexuality and to provide sex-related information to young people, their parents, and professionals. Its series of educational comic books, such as Ten Heavy Facts About Sex, VD Claptrap, and Protect Yourself From Becoming an Unwanted Parent have a combined distribution in sales and gratis copies of over 4,000,000. For three years (1974-1977), the Institute conducted A Community Family Life Education Program for Parents, an effort that trained 72 community leaders to lead sex education programs for parents. This program reached over 1,200 parents. Research indicated that this project, supported by a $250,000 grant from the National Institute of Mental Health, contributed to increased parent-child communication about sexuality (cf. Scales, 1979).

One of the Institute's most unusual projects has been National Family Sex Education Week. The week has been celebrated each October since 1975. It has encouraged hundreds of communities to engage in sex education activities. The week is a direct outgrowth of the First Wingspread Conference on Adolescent Sexuality and Health Care, held in 1974 with the support of a $10,000 grant from the Johnson Foundation. This conference convened sex education and adolescence specialists, foundation executives, religious leaders, and media representatives in an attempt to delineate plans of action. The following year, a $30,000 grant from the Sunnen Foundation provided support for the first NFSEW. Succeeding years have been supported by both Sunnen and the Scaife Trust.

The week is used to promote the idea that parents are the main sex educators of their children, and has sparked a wide variety of projects which, in combination, have reached thousands of teenagers across the country. Both educational workshops and media projects have been initiated, and it has been estimated that about $1 million of media time has been generated (Fanelli, 1978). In Dade County, Florida, for example, the week prompted the Sex Health Education Center of Miami to host a "Sex Symposium" which was attended by over 800 teenagers. The day-long event was endorsed by six county mayors and was covered extensively by newspapers, radio, and TV. Workshops offered at the conference included: parent-child communication, teenage pregnancy, birth control, cultural differences in sex, love and marriage, sexual self-pride, VD, homosexuality, and others.

Numerous other projects (cf. Fanelli, 1977, 1978) were encouraged by providing thousands of groups and individuals with slides, sample proclamations for legislators, hints on developing media contacts and preparing spots, and suggestions for involving libraries, churches, schools, and other community organizations. Libraries were encouraged to arrange book displays, churches were urged to incorporate sexuality issues into their bulletins and sermons, newspapers were asked to undertake community opinion polls on sexuality, students were encouraged to write articles on sexuality for the school newspapers, and resources were supplied for establishing hot lines and conducting surveys of community pharmacists, doctors, and sexuality

services. A journal containing these tips and other articles has been produced each year, and in 1978 reached over 50,000 key leaders across the country with the slogan "make 1979 the year of the wanted child."

For more information, contact:

Dr. Sol Gordon
Director
Institute for Family Research and Education
760 Ostrom Avenue
Syracuse, New York 13210

2. The Population Institute--Rock Project

The Population Institute has for years been a leader in the area of adolescent fertility and sex education. Their numerous projects have included the Youth Values Project, in which over one thousand New York City teenagers were surveyed by other teenagers who wrote the questions; the Youth Agency Leadership Project, which is training the staff of youth agencies in three pilot cities to meet the sexual health care needs of young people; the Campus Action Program, which supported projects such as establishing a women's center and conducting community surveys on sex-related issues; and a variety of projects in which consultation and training were provided.

The Rock Project started in 1975, and has been supported by funds from the Population Institute, the Scaife Trust ($196,000) and other foundations and individuals. About 50 popular recording artists have participated in the project by producing prerecorded public service spots on their own experiences and feelings about sexuality, parenthood, birth control, and interpersonal relationships. The spots won Billboard Magazine's "Best Public Service Announcement of the Year" Award for 1976. They are often humorous, and intersperse clips of the stars' top songs with their comments. Artists such as Linda Ronstadt, Fleetwood Mac, Alice Cooper, and others have contributed their time for the spots. The tapes are distributed free to radio stations--about 1,000 stations have received tapes, and evaluation suggests that about 800 stations have played them. The potential audience for these spots is in the millions. Because the Rock Project does not pressure the station management for airtime or monitoring of plays, the number of times the spots are played, the hours during which they are played, and the size of the audience, can only be estimated.

An educational package has been developed, including the best spots and many related questions and activities for teen discussion groups. These "Trigger Tapes" have been ordered by several hundred schools and Planned Parenthood affiliates. Private schools are more frequent users than public schools.

These activities have been aided by the project's Teen Consultant Group. This group of about ten Los Angeles area high school students evaluates all radio copy and makes suggestions for both radio and written material. They have also produced an issue of PREGNANT PAUSE, a quarterly newsletter sent to the music industry and featuring the sexuality-related themes of the rock project. In addition, the teenagers are conducting a survey of LA area pharmacies to determine which sell contraceptives without a hassle. The results are reported in their school newspapers. Currently, the Rock Project is cooperating with Planned Parenthood of Marin County to develop a series of two minute spots, which will then be used by trained teenagers to train adults as rap session leaders in sexuality.

For more information, contact:

Kathi Kamen
Director, Rock Project
The Population Institute
1111 Kearny Street, # 8
San Francisco, California 94133

Many other groups have undertaken sex education projects. For instance, the Future Homemakers of America with the March of Dimes has trained peer educators in over thirty states to reach an estimated two million other teenagers with messages on the relationship between teen pregnancy and birth defects. Puppet shows, slide and tape presentations and discussion groups have all been used. Similarly, the series of Love Carefully Days sponsored by Zero Population Growth on Valentine's Day have involved hundreds of groups and communities in outreach projects ranging from hot lines and call-in TV shows, to town meetings and a variety of peer projects in sex education. While much anecdotal information is available on both these projects, insufficient systematic information has been collected to describe them fully. More information is available from:

FHA
2010 Massachusetts Avenue, N.W.
Washington, D.C. 20036

and

ZPG
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036

In addition, an interesting project encouraging high school reporters to write articles about sexuality for their school newspapers was begun in 1978 by the National Alliance for Optional Parenthood. Press conferences for those high school students were held in seven cities, and the 300 teenage participants represented a combined circulation of 250,000 teenage readers. The teenage author of one article was selected as the winner of a national contest, and the article was reprinted in more than 300 U.S. newspapers in February 1979. More details are available from:

NAOP
3 North Liberty Street
Baltimore, Maryland 21201

VI. State and Local Government Departments

1. Georgia State Department of Human Resources

In one of the most ambitious projects across the nation, the Georgia State Department of Human Resources has initiated a state-wide effort to discourage early teenage pregnancy by stimulating local communities to support school initiatives in sex education and to adopt a variety of nonschool projects. Using the pregnancy prevention model developed in Dalton, Georgia, the planning process was begun in May 1978 to establish resource teams and community projects in all nineteen state health districts. Although the primary emphasis is on establishing support systems to assist schools in preventing adolescent pregnancy, both the composition of the resource teams and the range of current activities demonstrate an impressive degree of nonschool community involvement. Early meetings were held, for example, among DHR staff and representatives of the Georgia Academy of School Physicians, the Georgia Chapter of the Society of Obstetrics and Gynecology, the Family Planning Council, the Georgia Chapter of the American Academy of Pediatrics, the Council on Maternal and Child Health, the National Foundation March of Dimes, the Council on Problems of Children and Youth, and Atlanta Planned Parenthood.

In September 1978, a conference of these resource teams and others was held. It was called "New Horizons in Teenage Sexuality," and led to many different local projects. For example, District 1 is planning a teenage project with the Future Homemakers of America; District 2 has worked closely with the health department sex education initiative in the schools; District 3 has developed a local Teen Services Directory and is developing a high quality reference library in sex education; and District 6 has encouraged area ministers to lead teen rap groups, and to use a play called Peer Pressure. This district's emphasis on ministers is especially important, since it is also the district with the most active "Right to Life" group in opposition to these sex education projects.

Health District 10 is one of the most active. One emphasis is upon professional training. A second emphasis focuses upon improving the decision-making capacity of young people in the area of sexuality, and in postponing the beginning of sexual intercourse among adolescents. Their program is entitled "Project Teen Concern," after the pioneering San Francisco program of the same name (c.f. Project Teen Concern, 1975). One of its central features is a teen advisory board of ten teenagers to assist the adult professional in developing projects which are sensitive to teenagers' needs. The teenagers come from each of the district's ten counties.

In addition to these projects, numerous activities focus on training parents in sex education, raising professional awareness, and increasing media coverage of the need for and the development of sex education services and resources.

For more information, contact:

Noreen Beattie
Georgia Department of Human Resources
Maternal and Infant Care Unit
47 Trinity Avenue SW
Atlanta, Georgia 30334

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2. Santa Clara County (CA) Health Department

The Male's Place

Another example of a successful hot line operation is The Male's Place in San Jose, California. It was started in 1977. It received $29,000 for the first year and $45,000 for the second year from the State Office of Family Planning through the Santa Clara County Health Department. Although it was originally intended to provide information and referrals to men of varying ages, the primary callers are thirteen to nineteen. They get about forty calls a week. About ten percent are from females usually concerned with dating relationships, contraceptive information, and assurances that they're normal. Calling it the "Healthline," the staff notes that most contacts occur over the phone even though the Male's Place also has a drop-in center. Many teenagers apparently prefer the anonymity of the telephone, and many others simply lack transportation to the center.

Although the center sells condoms and foam, it is primarily an educational center, not a clinic. Clients with medical concerns are referred elsewhere. In addition to the Healthline, the staff has also made presentations to about 110 groups of teenagers in the community, including talks at schools and YMCA's. These presentations make use of role playing as well as questions and answers.

From its inception in January 1977 until December 1978, over 6,000 men and women and 1,500 teenage males had either used the telephone service or visited The Male's Place. Outreach has been extensive, including all fifty-five high schools in the county. At one of the high schools, staff of The Male's Place have developed a curriculum on VD, birth control, and dating relations that will reach every sophomore in the school. All presentations, whether outreach or in-house, are done by a team of men and women. Currently, there are three men and four women on staff.

The Male's Place has an active program of professional consultation as well. It concentrates on helping family planning staff identify their needs in the area of male involvement and on helping them plan programs of improvement. Several conferences have been held for this purpose. In addition, research is just being completed with several hundred young men to determine their attitudes, knowledge, and feelings about sexuality and their receptivity to programs intended for them. An increase in the yearly budget up to $80,000 has provided the means of support for this research, as well as for the preparation of a detailed education manual outlining the structure and suggested content of approaches to men. In addition, a new program has begun in which staff are working with parent groups and with local labor unions and are providing them with information and resources intended to increase parents' communication about sexuality with sons.

For more information, contact:

Steve Purser, MPH
Health Educator
The Male's Place
976 Lenzen Avenue
San Jose, California 95126

VII. Programs for Pregnant Teens/Teen Parents

1. New Futures School

New Futures School is a comprehensive program for school-age parents in Albuquerque, New Mexico. It offers a wide variety of services including continuing regular education, health, counseling, and social services, infant and day care, counseling for the father and extended family members, and community outreach. About 450 young mothers thirteen to nineteen are served in regular classes, and an additional 300 receive individual counseling. Over half of the clients are of Hispanic heritage and about thirty percent are Anglo. School districts, vocational educational funds, Titles X and XX funds, and HEW research grants provide most of the $364,000 annual budget.

Family planning is a major component of the services, but the approach to family planning is not simply the provision of education or services, but rather a program which supports self-concept and understanding of relationships. According to the program coordinator, "the why of family planning must be understood before the how is meaningful." Thus, in addition to basic factual information on reproductive anatomy, pregnancy, and birth control measures, the program covers responsibilities of being a parent, infant and child development, development of positive self-image, personal needs causing pregnancies, relationships with father and family, and women's roles today. The importance of education and job skills is stressed. In addition to the teaching, nursing, and counseling staff, former students also assist in the program. In 1977, results of a longitudinal evaluation study were reported, indicating a repeat pregnancy rate of two percent after six months, six percent after one year, and nineteen percent after two years. Many of the latter, however, were planned pregnancies.

Outreach to the community is an important part of the New Futures Program. In 1978, nearly 100 community presentations were made, directly reaching about 2,800 teenagers. Groups such as regional student council conferences, state Future Homemakers of America conferences, Planned Parenthood affiliates, church youth groups, and the March of Dimes are among those to whom presentations were made. This outreach typically consists of playing the slide and tape show, "I'm not Bad, Just Pregnant," followed by discussion and question and answer periods. The show was produced entirely by the students for about $700. They wrote, acted in, and composed the music for the thirty-minute production. The show covers three main areas: 1) how they became pregnant (e.g., they were raped, they just "gave in," they thought they would probably get married anyway, etc.); 2) how they told their parents and their boyfriends; and 3) what decisions they needed to make (whether to get an abortion or continue the pregnancy, how their pregnancy would affect significant others in their lives, how their lives would be changed, etc.). Current and former students lead the ensuing discussions.

For more information, contact:

Caroline Gaston
Program Coordinator
New Futures School
2120 Louisiana, NE
Albuquerque, New Mexico 87110

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2. Home Front

Home Front is a new program of the eight year old Bridge Over Troubled Waters (The Boston Network of Alternative Runaway Services). Home Front is intended to be a refuge for girls who are unintentionally pregnant, and who, in addition, are part of the population of "alienated" teenagers in the Boston area. The program was funded by the Youth Development Bureau of HEW for $81,000 in 1978 and by the Mott Foundation for $75,000 in 1979. Home Front provides single-site, comprehensive health care services and social services for alienated youngsters who are pregnant. Its variety of outreach mechanisms (e.g., street workers, medical vans, hot lines, and drop-in centers) are used to identify and recruit Home Front clients. A key objective is linking the teenagers with other service providers while supplying a single-site atmosphere of home-like care. During the project's first year, 150 clients were involved in-depth on a daily basis (fifty mothers, fifty children, and fifty significant others, including both friends and persons related to the mother and child). An additional 300 clients were given short-term pregnancy counseling (including abortion reference and follow-up). Other medical, educational, and social counseling is also provided.

Over eighty percent of Home Front clients have run away from home at least once before becoming pregnant, and many had alcoholic parents. Before they became pregnant, about two-thirds of the clients lived on the streets, in apartments rented by friends, pimps, or pushers. Over eighty percent are high school dropouts. For this group, pregnancy followed dropping out, not the reverse. Over seventy percent use drugs daily, and about one-third made their living through prostitution. Over eighty percent are under eighteen years old.

Th main objectives of Home Front are to prepare, educate, and train these teenagers to live without drugs and to be economically independent. The program offers parent education, household maintenance and breadwinning skills, and psychological, social, and health training. A ten month, twenty hour per week curriculum is used. It emphasizes informal discussions on the following topics: adolescent gynecology; birth control information; health care consumer information; family life education; and a variety of parenting topics, such as child development, child abuse prevention, and single parenting. Many of the clients do not initially feel comfortable talking about sexuality. However, most of them do want to know "how soon they can start having it" after the baby is born, and this question provides the entry into a discussion of the client's past sexual history and future expectations. Counseling and education are intended to focus on helping the client make decisions about sexual problems and her new family life. They try to answer the following kinds of questions. "What kinds of relationships does she want with both men and women? What is she prepared to give in these relationships? What kinds of relationships promote both her and her child's well being? What are her motives for becoming sexually involved?"

Evaluative research is currently underway, with results expected in 1980 and 1981. The research will begin to assess the extent to which the following specific goals for the teenage mothers are being met:

1. they will have no repeat pregnancies
2. they will exhibit drug-free behavior before, during, and after pregnancy
3. they will establish and maintain suitable housing
4. they will establish a daily routine that promotes emotional and physical well-being for both mother and child
5. they will provide nutritional, emotional, and physical care for their children
6. they will make a commitment to a school or job training program, and will procure income legally
7. they will terminate welfare support within a maximum of six years.

For more information, contact:

Kristen Mitchell
Project Director
HOME FRONT
Bridge, Inc.
23 Beacon Street
Boston, Massachusetts 02108

The directory prepared by the National Alliance Concerned with School Age Parents in 1976 lists more than 1,200 providers of services nationwide for pregnant teenagers, teenage parents, their children, and their families. While many offer sexuality education as part of their services, most tend to be short-term care providers whose educational efforts focus on parenting skills. Many adopt the approach cited by the Florence Crittendon Homes. There are about thirty-three such homes nationally, serving about 1,000 teenage women. While there may be occasional presentations on birth control, or periodic discussions on relationships and communication, most of the sexuality education occurs individually and spontaneously as needs arise in conversations between the client and the social worker.

3. Tri-County Health Department, Denver

Tri-County Health Department serves the Denver Metropolitan area and offers a variety of outreach workshops for teenagers in the area of sexuality education. Before each workshop, department staff meet with agency leaders and teenagers to plan specific objectives and content for each group. Thus, no single curriculum is used. Content is usually drawn, however, from among the following topics: birth control methods, assertiveness training, sexual attitudes and values, homosexuality, pregnancy, sex roles, self concept, sexually transmitted diseases, sex education in the schools, media influences on sexual values, values clarification, teenage relationships, and teen parenting. Activities designed to facilitate communication are typically included.

One type of outreach workshop is with alternative high schools. These programs are tailored for potential drop outs or teenagers who have already dropped out of school. In these, as in most other kinds of workshops, the approach is experiential. The purpose is to raise awareness of sexual attitude and values and to encourage responsible decision making. The alternative school workshops usually consist of six sessions, each lasting two hours. They make heavy use of values clarification exercises, psychodrama, films, moral dilemmas, and media (e.g., rock music). In 1978, these workshops reached 120 teenagers.

Another important outreach component is the work with juveniles at correctional facilities. Detention centers and shelters for adolescents are visited for about five sessions, each lasting two hours. Self-concept, adolescent sexuality, and relationships with peers are emphasized in these sessions, which makes use of values' clarification exercises and media resources. In 1978, eight workshops were held reaching about 100 teenagers.

In addition, other outreach efforts include classroom presentations in the local schools, usually at the request of a teacher. Tri-County will not do a "one-shot" session, so the school typically contracts for them to conduct three sessions per workshop per class. In 1978, fourteen workshops were held, reaching about 420 teenagers. Workshops are also designed for parents. They concentrate on expectations of relationships and sex roles. In 1978, forty teenagers were reached. Tri-County is involved in several new projects. The Crysalis Project teaches parenting skills and aims to enhance the self-concept of teenagers identified by their schools as high-risk (about thirty were reached in 1978). The RAM Project is intended to encourage responsible use of birth control among teenage males. The first workshop in this series takes place in spring 1979, and is funded by HEW through the family planning program at the Colorado Department of Health. The cost for these direct services to teenagers is about $6,000. This figure covers the outreach worker's salary, but excludes materials.

For more information, contact:

Vicki Linnertz
Tri-County Health Department
7475 Dakin Street, Suite 401
Denver, Colorado 80221

4. Berkeley (California) Health Department

In 1978, the family planning office of the Berkeley Health Department started its "peer educators on campus" program. The current funding of $55,000 is roughly half the needed amount. The intent of the program was to train peer educators to work both in high schools and in communities. Approximately twenty young people have been trained in the first year. They receive a full curriculum in adolescent health, including facts about sexuality and training in decision making, values clarification, and communication. During the 100 hours of training, and during their actual work in peer education, they are paid approximately $2.90 per hour. Typically, they work about ten to fifteen hours a week during the school year and full time during the summer.

In addition to giving presentations and functioning as referral sources in the social living classes at Berkeley High School, the peer educators hold rap groups at the YMCA, at the teen clinics of local hospitals such as Children's Hospital in Oakland, and at local parks through the help of the Department of Parks and Recreation. It is estimated that the twenty peer educators reached 500 others directly in 1978. One of the most successful programs of the year was an adolescent health workshop held in November 1978 for 250 area teenagers. Eight sessions were held in the areas of VD, sexuality, birth control, pregnancy and options, health careers, and others. The majority of the attending teenagers expressed an interest in becoming peer educators themselves. The present peer educators are equally enthusiastic. T-shirts have just been ordered for them to wear, identifying them as "peer educators on campus."

Community response has been very positive. Parents are involved toward the end of each training period, when a "pot luck" supper is held and the peer educators demonstrate what they have learned and the kinds of work they are doing. Parental permission, however, is not required. To date, no parental complaints have been received.

For more information, contact:

Ida Castillo
Community Health Worker Specialist
830 University Avenue
Berkeley, California 94710

Several other state departments provide exemplary service for their adolescents. Virginia's Bureau of Family Planning, for example, uses a variety of media approaches, from billboards to school newspapers to hot lines, to provide information and stimulate use of family planning clinics. Florida's Department of Health and Rehabilitation Services has helped form a broad-based alliance for responsible adolescent parenting, as well as compiled an inventory of services for adolescents, describing in detail the services offered by several hundred Florida programs.

For more information, contact:

Steve Calos
Bureau of Family Planning
109 Governor Street
Richmond, Virginia 23219

and

Spencer Lieb
PDHED-Disease Control Program
1323 Winewood Boulevard
Tallahassee, Florida 33301

VIII. Hospital Programs

1. Emory University/Grady Memorial Hospital Family Planning Program

The Grady Hospital program is multifaceted, providing both clinical services and education to teenagers who are pregnant or post-partum, and also to those who are sexually active but not pregnant. Titles X, XIX, and XX accounted for $735,000 of FY 1978's $1.2 million budget, with the hopsital providing most of the rest--patients pay only about one percent of the total. In FY 1978, nearly 6,500 teenagers were seen for patient care including birth control counseling, gonorrhea treatment, post-abortion counseling, and postpartum classes. Social services are also provided to low-income patients. Grady's Outreach Section provides a four-part human sexuality and family planning session in schools and community agencies, primarily to counteract myths about the safety and effectiveness of birth control methods. The outreach staff also provides family planning counseling at various city health fairs. Grady's Education Department is well known for a variety of publications, among them What's Happening (a magazine for teenagers), The Joy of Birth Control, Sex and Birth Control for Men--The View From Our Side, and the widely used Contraceptive Technology, updated regularly.

Grady's most unique contribution to nonschool sex education was 1978's "What's Happening" Conference. This first national health conference for teenagers drew 2,700 young people and 500 professionals to two days of activities. A wide variety of lectures, films, small groups, and exhibits provided considerable information. The real aim, however, was to affect decision making on a variety of health issues, including alcohol, smoking, contraception, blood pressure, and sickle cell testing. The conference was the culmination of five years of planning during which several large professional conferences were held. The focused planning for" What's Happening" began in July 1977, just under a year before the event. Ten different committees coordinated the event, and the chairpersons of each committee met every three weeks for one year. Considerable effort was spent in establishing community support, especially from leaders of the religious community and the schools. Both the Mayor of Atlanta and Georgia's Governor issued proclamations naming the conference week as "Teenage Health Week." A number of public and private contributors, in addition to registration fees, helped defray the $40,000 budget. For example, the Emko Company and the Georgia Department of Human Resources, each donated $10,000.

At the conference, teenagers were encouraged to actually make health decisions. It was hoped that some 20,000 individual decisions would be made at the event (e.g., making an appointment for family planning services, learning how to perform a breast self-exam, and voting on sex education issues in a conference poll). In addition, each teenager was scheduled for four hours of small group discussion to be focused on common questions of teenagers (e.g., "Are my sexual feelings normal?" "Do any methods of birth control cause cancer?" "How do you say no when you really don't want to have sex?", etc.).

The conference included two major presentations which dramatically presented teenagers with information about decision making and self-respect. The performance of the Family Life Theater's Teen Machine, and the talk by the Rev. Jesse Jackson were the two most highly rated aspects of the conference. Part of the Teen Machine's performance covered sexuality and teenage pregnancy, but its main concern was to dramatize the lives of teenagers and to portray a broader view of teenagers.

Although each teenager was asked to make twelve decisions during the conference, an adequate means of collecting evaluation questionnaires was not devised, and few were actually turned in. Thus, a brief post-conference questionnaire was the main source of structured evaluation. The plays, skits, exhibits, films, and performances by Rev. Jackson were the most highly rated activities. On a scale of one to five (very little to very much), the teenagers liked the conference (4.6) and felt they learned something at it (4.0), but were less convinced that the conference changed their ideas about health (3.7). Suggestions for change, in addition to holding a smaller conference, were to limit the number of speakers and devote more time to small groups, possibly assigning each group a topic so that teenagers could select groups and topics.

For more information, contact:

Dr. Robert A. Hatcher
Director
Emory-Grady Family Planning Program
69 Butler Street SE
Atlanta, Georgia 30303

2. Columbia-Presbyterian Hospital, New York City

The Center for Population and Family Health started a young adult clinic at Columbia-Presbyterian Hospital in 1977 with a grant from HEW. A Community Health Education Unit for outreach was established in 1978 with two private foundation grants. About 2,000 clinic visits were made by teenagers in the first year, ten percent of which were by young men. It is estimated that 6,000 visits will have been made in FY 1978-79, at a total program cost of about $360,000.

The clinic offers counseling and contraceptive services to the Washington Heights area of New York, which has been one of the highest-risk areas in the city for adolescent pregnancy. The teenagers who come to the clinic reflect the cultural and racial balance of the surrounding community. About half are Black and about forty percent are Hispanic. All of the staff are bilingual in English and Spanish. The clinic is open twice a week in the late afternoons and early evenings and has seen a four-fold expansion in the number of vists per month in the first year. Nearly forty percent of the patients are under 17 years of age and the number of visits by those younger than fifteen increased rapidly in the first year. Referrals to the clinic due to outreach and to word-of-mouth recommendations nearly doubled between the first half of the year and the second half.

Two outreach workers are primarily responsible for work in the community. Priority has been placed on making presentations to high schools. Presentations are also made to parents of elementary students in an effort to reach the children at a much younger age than is usual. The program formed a community advisory board of church representatives, youth group leaders, physicians, and teenagers. Even in this heavily Catholic-Hispanic community, the programs report that there has been no formal opposition by Catholic groups to the provision of sex education and contraception.

During the summer, presentations are made in parks, playgrounds, art centers and other locations. Bi-monthly adolescent sexuality workshops are being held with the Family Planning Health and Guidance Clinic of the Community League, West 159th Street, and the Community Mental Health Council of Washington Heights is collaborating on several projects. The first of these is in conjunction with the CETA funded Harlem Juvenile Diversion Project. The Diversion Project will assist in selecting community young people to be trained as peer educators. In addition, the NYC Board of Education has requested that twelve sessions on values, decision making, and adolescent reproductive and sexual health care be held at two high schools. This pilot education project is intended to increase use of services.

Extensive evaluation is being conducted at several levels, including patient evaluations, measure of the impact of community outreach, measures of the impact of patient education, and an anonymous participant-observation study of the clinic which has resulted in some immediate changes in clinic practice (see Scales, Etelis, & Levitz, 1977 for a detailed account of such a clinic study).

For more information, contact:

Judith E. Jones
Assistant Director
Center for Population & Family Health
80 Haven Avenue
NY, NY 10032

3. University of Pennsylvania Medical School--Family Planning Program

After several years of providing obstetrical and social services for pregnant teens, the Family Planning Program was begun in 1973 for never-pregnant high school students. Members of the hospital staff, with the assistance of high school classroom teachers, give a series of six instructional and discussion sessions predominantly for junior and senior year students. The health or psychology classes of three high schools are the primary locations for these sessions. Initial contact with the school nurses provided the entry point for the program. The topics include attitudes about sexuality, personal relationships, venereal disease, pregnancy, menstruation, and family planning. Following the series, any student may request contraceptive or other gynecological services to be provided during school hours at the hospital Family Planning Program. All services are supplied without charge and without parental consent. A patient is scheduled for four visits during the first two months, followed by visits every three months over a minimun of two years. An interesting program component is that another student who is known by the program participants, calls each girl after a missed appointment to determine why the appointment was missed. This technique apparently encourages participants to keep their appointments. Currently, sixteen health education classes are being visited for three days a week.

School nurses have been particularly helpful in the project by referring students to the program health educator. The health educator gives her business cards at presentations, and invites the students to call at work or at home. She receives about two to three calls per night at home. The outreach component of the program costs about $13,000 per year, and has been supported primarily by foundations. Recently, however, it has been funded by the Family Planning Council of Southeastern Pennsylvania, the local conduit for Title X funds.

Since its inception, over 800 never pregnant young women have enrolled in the family planning program because of this approach to the high schools. Between mid-1973 and 1975, 161 students enrolled in the program. All were Black, unmarried, never-pregnant, and attending high school. Nearly half lived in single-parent households, and most came from low-income families. An evaluation was conducted of program participants by comparing three groups: 1) those who continued in the contraceptive program 2) those who became pregnant after their enrollment, and 3) those who discontinued the program. Among the ninety-four students who enrolled in the program's early days, and who could thus have continued in it for two years by the time of the study, sixty-three percent had continued for one year without a pregnancy, and thirty-four percent for two years without a pregnancy. These continuation rates fall in the mid-range of rates reported for U.S. family planning programs. Only ten percent of the total sample of 161 experienced an unintended pregnancy. Most of these occurred in the program's early months. The result suggests that increased contact with patients in the initial months of their contraceptive program may be the most crucial factor in encouraging contraceptive success. Overall, students who had unintended pregnancies missed more appointments and had more complaints about contraceptive side effects.

For more information, contact:

Dr. George Huggins
Dept. of Ob/Gyn
Hospital of the University of Pennsylvania
3400 Spruce Street
Philadelphia, PA 19104

Another hospital-based program is just beginning and incorporates several unique components. The Adolescent Services Program at San Francisco General Hospital is lead by a team of pediatricians, social workers, community health experts, and teenagers. They supervise a wide range of counseling and educational projects. The program will pay particular attention to the needs of sexual minorities (e.g., homosexuals and prostitutes). A city-funded program called Child and Adolescent Sexual Abuse Resource Center has direct links to the program, as does the Juvenile Hall of San Francisco and the Adolescent Family Planning Clinic. Peer educators are being trained to make presentations to schools and other community agencies (e.g., the city VD clinic, Youth Advocates of San Francisco, Centro Latino, and the Women's Center). In addition, a well-baby clinic and a school for pregnant teenagers are also included in the program. More information is available from Dr. Richard C. Brown, Director, Adolescent Health Services, San Francisco General Hospital, 1001 Potrero Avenue, San Francisco, California 94110. In addition, Moore, 1977 describes several other hospital-based programs including sex educaton components for young people.

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Chapter 6:

AN ANALYSIS OF STATE GUIDELINES FOR SEX EDUCATION INSTRUCTION IN PUBLIC SCHOOLS

Introduction

In recent years, the sex education literature and debates have focused primarily upon curricula for programs, examples of programs, and the effects of programs, but have largely ignored the legislative basis for sex education programs. This lack is particularly pronounced because many states have developed guidelines for sex education. Thus, numerous important questions remain unanswered: e.g., What guidelines do states provide for their educators? What degree of authority may local school districts assume in developing their own approaches? Are certain topics prohibited from classroom content? How much preparation should teachers have? How should parents and the community be involved, if at all? Do state guidelines carry the force of law or are they just suggestions? Are they clear, or do they leave room for considerable interpretation? Do guidelines differ by region of country? To what extent do guidelines affect the proportion of schools offering separate courses in sex education?

In 1976 and again in 1978 data were collected for the American School Health Association (American School Health Association, 1978; Castile and Jerrick, 1976). Although these surveys focused on other health matters, they did provide information on whether or not state guidelines required the inclusion of sex education topics in the health curriculum. Their finding that six states and the District of Columbia require some form of sex education was given wide circulation by the Alan Guttmacher Institute in its 1976 report 11 Million Teenagers, and has been cited extensively in both popular and professional literature (Alan Guttmacher Institute, 1976). A more recent study of state departments of education by Sullivan, Gryzlo, and Schwartz adds some confusion to the earlier findings (Sullivan, Gryzlo and Schwartz, 1978). Sullivan, et al., received replies from only 43 states, and Castile and Jerrick covered all 50. The two studies could agree only that Maryland requires some form of sex education. Each study listed several states as mandating sex education, but Maryland was the only state named by both studies.

The present study was intended to answer the questions raised above, to resolve the differences in previous studies, and more generally to provide additional information about the states' view of the planning process, the content and the organization of sex education programs.

Methods

The data for this study were obtained by completing a "Summary of Laws and Guidelines for Instruction in Sex Education" for each state. The

categories included in this summary sheet were determined through three steps. First, the features rated as most important by the professionals were collapsed into several broader categories for the present study. Second, several sex education professionals serving as consultants supplemented this first draft. Third, several reviews of the guidelines received from the states indicated that a few additional features of guidelines should be added because some states included them, and that a few should be removed because the guidelines offered no information on them. The final summary sheet is in the appendix and provides the basis for Table 6-1.

To determine whether each state has guidelines for sex education instruction and to obtain those guidelines if they exist, we telephoned each state's Department of Education and then sent the appropriate person in each state a letter. To those states which did not respond, we made additional calls and sent additional letters (including a formal letter from the Center for Disease Control) until all 50 states responded.

An initial examination of the states' guidelines demonstrated that obtaining the desired information from them would not be easy nor error-free. Moreover, our early analyses suggested conclusions that differed from those of previous scholars. Thus, three steps were completed to assure that the results are reliable and valid.

First, two individuals coded the guidelines for twenty-two of the states with guidelines. The remaining guidelines were received at a later date and could not be coded by both individuals. Whenever the coders disagreed, the difference was discussed with a third party, and, if necessary, the state was called for clarification. These decisions were then used in the summary sheets.

Because there were two distinct steps in the coding, there are two inter-coder reliability checks. In the first step, the coders determined whether or not the guidelines of a particular state mentioned one of the components on the summary sheet. In the completion of this step, the coders agreed 88.4% of the time. In the second step, the coders then had to determine whether the guidelines of a particular state legally required, suggested, discouraged, or prohibited guideline components. On this rating, the coders agreed 96.9% of the time. In other words, the coders were less likely to agree on whether or not some program component was even mentioned at all, while they were more likely to agree on the particular rating if mentioned. Obviously, both reliabilities are high by social science standards.

To further ensure that the results are reliable and valid, all summary sheets were completed and then returned to the separate states for their verification. Many states verified that our analyses were correct. Others made some changes in our ratings. Whenever we differed with those changes, we telephoned those states (if they had not already telephoned us), and we reached a consensus with the state. Although we made additional efforts to receive verification from all states, seventeen of the states did not return

any comment on our analyses, either pro or con.

Third, we telephoned all states that other studies said mandated sex education and that our data said did not mandate sex education. In all cases, our data were clearly verified.

Results

The guidelines we received range from just a single paragraph (e.g., New Hampshire and Tennessee) to several books of recommendations, curriculum approaches, and suggested methods (e.g., New York and South Carolina). They also vary considerably in clarity; some are remarkably clear and detailed, while others are quite confusing.

Part of the confusion is caused by vague terminology. For example, some states (e.g., Kansas and Utah) discourage the discussion of "sexual techniques" or "sexual behavior". Do these terms include only the special techniques of sexual intercourse? Or sexual intercourse more generally? Or petting? Or kissing? Or masturbation? Similarly, other states (e.g., Minnesota) discourage the discussion of "perversions". Obviously, in our very heterogeneous culture different people consider very different activities to be "perversions". Minnesota did assure us that it did not consider masturbation a perversion, but that it did include homosexuality in this category. A few other states suggested that all sex education teachers had to be "comfortable" with teaching sex education and also "competent". Do these terms imply that teachers must have special attitudes or training? According to Missouri, "competent" does mean special training. Finally, there are the fine distinctions between discussing an activity, suggesting acceptance of that activity, and advocating an activity. In Minnesota, for example, birth control methods may be discussed, but not advocated. Similarly, in Utah, teachers may discuss homosexuality, but cannot state or imply that it is a normal or acceptable activity. On paper these distinctions may be clear, but in the classroom, the distinctions may become blurred, especially when students ask questions such as "Which is better for you, the pill or the IUD?" or "Do you think homosexuals are normal?"

The legality of the guidelines produced a second source of confusion. In some states, guidelines are simply recommendations which local school boards can accept or ignore. In other states, those portions of the guidelines with phrases such as "schools are required to" are legally binding, but portions of the guidelines based on phrases such as "schools should" are not so binding. In a few states, all the guidelines have the force of law, but the law is commonly and openly violated and almost never enforced. Finally, in the remaining states, schools treat the guidelines very seriously, for they are legally binding and are enforced. For the discussions below, we did try to determine the extent to which they are followed and enforced.

Although these ambiguities produce minor problems for the researcher, they have both positive and negative consequences for the school teachers, administrators, and legislators. On the one hand, they may give teachers

greater freedom and may allow legislators to avoid unnecessary conflict. On the other hand, misunderstandings may overly restrict some teachers and produce unwelcome pressure from community forces or the administration.

In Table 6-1 are the state by state summaries of the guidelines. This table indicates that forty states have guidelines on sex education.

According to these data, only Maryland and Kentucky require sex education and only Louisiana prohibits it. The first part of this conclusion differs from both the two American School Health Association studies and the Sullivan, et al. study. Apparently, those previous studies contain errors. For example, according to ASHA, Michigan requires sex education. Although Michigan does require instruction in communicable diseases including venereal disease, both Michigan Law PA 226 and the Michigan State Department of Education say that instruction in "reproductive health, including family planning" is legal, but not mandatory. Similarly, at least one of the previous studies specifies New Jersey and North Dakota as requiring sex education, but according to officials of those respective Departments of Education, neither state has active guidelines, much less mandates. As indicated above, in all cases of disagreement between our findings and the ASHA results, we telephoned the state's Department of Education and our findings were confirmed.

Involvement of Parents

Three of the four most commonly recommended or legally required program components are 1) involvement of parents and community in planning, 2) local autonomy over programs, and 3) public review of program content. Significantly, more than half the states' guidelines recommend these components, but no state discourages any of them.

The emphasis placed upon these three components apparently reflects both the desire to design each program for the particular needs of that community and to involve parents in sex education instruction. There are at least three reasons for including parents. First, the purpose of most school instruction in sex education is to supplement, not supplant, home instruction. When parents are more involved in school instruction, they can more accurately and more comfortably discuss sexual matters with their children. Second, parental involvement in the planning process will presumably improve the quality of the programs. Third, when parents are involved in the planning, they are more likely to support the final program and to mute potential opposition. Studies indicate that parents are most likely to be antagonistic to sex education when they are poorly informed and uninvolved (Scales, 1979; Thoms, 1978).

Only a few states recommend classes for parents which complement the student's classes. Thus, states may be overlooking a significant means of involving parents and strengthening the program. Without such classes, many parents are unable to adequately discuss sexual matters with their children and they are less likely to provide the program with support. In fact, when parents are involved in program planning, they frequently request such sex education for themselves (Scales, 1979).

	AK	AL	AZ	CA	CO	CT
Program Components	JS	JS	JS	JS	JS	JS
sex education instruction[2]	SS				SS	SS
involvement of parents/community	SS		R		SS	SS
local autonomy over programs	SS	SS			RR	SS
public review of content			RR	RR		SS
periodic evaluation	SS				SS	SS
horizontal integration	SS					SS
vertical presentation	SS				SS	SS
special teacher training	SS	SS			SS	SS
approval by local board			RR			SS
approval by state board[3]		SS	RR			
advanced parent notification of student participation			S	RR		SS
parental permission to attend			S			
parental permission to be absent[4]		RR		RR	RR	
special sex education classes[5]			P			
co-educational instruction[6]			P			
test questions on personal sexual beliefs, etc.			PP			
individual counseling						
classes for students' parents[7]						SS
Topics for Discussion/Activities						
anatomy/physiology	S					
human reproduction[8]	SS				S	
venereal disease[9]	S				SS	
family roles/responsibilities	SS				SS	
adolescent/adult attitudes and values about sexuality			D			
sex roles[10]	S					
communication skills					SS	
decision-making and problem-solving skills	S				SS	
contraception[11]	S					
abortion[12]			D			
masturbation			PP			
homosexuality[13]	S		PP			

Key:

JS = junior/senior high school
R = legally required
S = suggested, recommended, presented as part of model curriculum
D = discouraged explicitly
P = legally prohibited
Blank = not mentioned in guidelines

Table 6.1

Sex Education Guidelines for Each State[1]

DE	FL	GA	HI	ID	IL	IA	KS	KY	LA	MD	MA	MI	MN	MO	MT	NH	NM
JS	JS	JS	JS	JS	JS	JS	JS	JS	JS	JS	JS	JS	JS	JS	JS	JS	JS
	SS	SS	SS		SS	SS	SS	RR	PP	RR		SS	SS	SS			
SS	SS	SS	SS	SS	SS		SS			RR	RR	RR	SS	SS			SS
SS	SS	SS	SS	SS	SS		SS	SS			RR		SS	SS			SS
	SS	SS					SS			RR	RR	RR	SS	SS			
SS	SS	SS	SS	SS	SS		SS			RR		SS	SS	SS	SS		SS
	SS	SS	SS		SS		SS	SS		RR			SS	SS			SS
	SS	SS	SS		SS	RR	SS			RR			SS	SS			SS
SS			SS	SS	SS		SS	S		RR		RR	SS	S			SS
SS							SS	SS		RR		SS	SS	SS			SS
				SS													
										RR		RR					
				SS						RR							
	SS		RR		SS					RR		RR					
	DD	SS	DD		S		DD		PP	RR			S				DD
		SS	SS		S								SS				S
									PP								
			S										SS				
					SS		SS			RR			SS				SS
SS	SS	S	SS	SS	SS		SS			RR		SS	SS	SS	SS	RR	SS
SS	SS	S	SS	SS	SS		SS	S		RR		SS	SS	SS	SS		SS
	SS	S	SS		SS	RR	SS	SS		RR		RR	SS	SS	SS	RR	SS
		SS	SS	SS	SS	S	S	SS		RR		SS	SS	SS	SS		SS
SS	SS	S	SS		SS								SS	SS	SS		SS
	SS	SS	SS		SS					RR		SS	SS	SS	SS		SS
		SS	S										SS	SS	SS		
	SS	SS	SS		SS					SS		SS	SS	SS	SS		SS
		S	SS		DD		DD			RR		SS	SS				
		S	SS		SS							DD	S		SS		SS
					SS										SS		SS
			S							SS			DD				DD

NY	NC	OH	OK	OR	PA	RI	SC	TN	TX	UT	VT	VA	WA	WI	WV
JS	JS	JS	JS	JS	JS	JS	JS	JS	JS	JS	JS	JS	JS	JS	JS
SS	SS					SS	SS	SS	SS	SS	SS	SS		SS	
SS	SS	SS		SS	SS	SS				SS		SS	RR	SS	
SS	SS	SS		SS	SS	SS				SS		SS	SS	SS	
SS	SS	SS	SS	SS					SS	SS		SS	SS	SS	
SS	SS		SS		SS						SS	SS	SS	SS	
SS	SS					SS	SS	SS	SS			SS	SS	SS	
	SS			SS	SS	SS	SS		SS				SS	SS	SS
SS	SS	SS	SS	SS	SS						SS	SS	SS	SS	SS
SS	SS		SS					RR				SS	SS	SS	
								RR				SS			
	SS												SS	SS	
		SS	SS											SS	
RR		SS									RR		RR	RR	
	SS				DD				S		D	SS	DD		
SS	SS								SS		D				
											DD		PP		
	SS	SS													
	SS		SS		SS									SS	
SS	SS			SS	SS	SS	SS		S	SS	SS	SS	SS	SS	SS
SS	SS			SS	SS	SS	SS		S	S		SS	SS	SS	
	S			SS	SS	SS	SS		S	S	SS	S		SS	
SS	SS			SS	SS	SS	SS		SS	SS		SS	SS	SS	SS
SS	SS				SS	SS	SS			S		SS		SS	
SS				SS		S	SS			S		SS		SS	
SS	SS					S	SS					S		SS	
SS	SS					SS	SS					SS	SS	SS	
		DD				S				DD		SS		SS	
												SS			
												S			
		DD				SS				S					

Table 6.2

Summary of State Laws and Guidelines for Sex Education[1]

Program Component	Ratings of Guidelines							
	Junior High School				Senior High School			
	R	S	D	P	R	S	D	P
sex education instruction[2]	2	22		1	2	22		1
involvement of parents and community in planning	5	21			4	21		
local autonomy over programs	2	24			2	24		
public review of program content	5	17			5	17		
periodic evaluation of classes or programs	1	23			1	23		
horizontal integration of material	1	20			1	20		
vertical presentation of material (e.g., K-12)	2	21			2	21		
special training for sex education teachers/staff	3	20			3	20		
approval by district or local school board	5	12			3	13		
approval by state school board[3]	2	3			2	3		
advanced parent notification of student participation	3	4			3	5		
parental permission to attend	1	2			1	3		
parental permission to be absent[4]	9	4			9	4		
special classes focusing on sex education[5]	1	4	6	2	1	5	7	1
co-educational instruction[6]		7		1		8	1	
individual counseling		3				4		
classes for students' parents which complement students' classes[7]	1	9			1	9		
test questions on students' personal sexual beliefs, attitudes, behaviors			1	3			1	3

Topics for Discussion or Activities								
anatomy and physiology	2	23			2	24		
human reproduction [8]	1	22			1	25		
venereal disease [9]	4	19			4	19		
family roles and responsibilities	1	24			1	26		
adolescent and adult attitudes and values regarding sexuality		16	1			18		
sex roles [10]	1	14			1	17		
communication skills		12				12		
decision-making and problem-solving skills		18				19		
contraception [11]	1	5	4		1	8	4	
abortion [12]		5	1			8	1	
masturbation		4		1		2		1
homosexuality [13]		3	3	1		5	3	1

Key:
R = legally required
S = suggested, recommended or presented as part of a model curriculum
D = discouraged explicitly
P = legally prohibited
Blank = not mentioned in guidelines

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Footnotes to Tables 6-1 and 6-2

1. The following states do not have guidelines: Arkansas, Indiana, Maine, Mississippi, Nebraska, Nevada, New Jersey, North Dakota, South Dakota, and Wyoming.

2. New Jersey had guidelines, c. 1967, which were entirely voluntary. They no longer send these guidelines to anyone, including their own school districts. In April 1978, however the head of the state board of education was quoted as calling for a consideration of mandatory sex education (Newark Star-Ledger, April 6, 1978).

   Maryland refers not to "sex education" guidelines, but rather to "family life education and human development".

   Louisiana clearly prohibits separate classes in sex education, or classes "by any other name" in which human reproduction is a "primary" component. Legislators are currently divided, however, on whether this means all "sex education" topics are prohibited from other courses. Legislation has been introduced to clarify these issues (HCR 235 - Alan Guttmacher Institute, 1978).

   Kentucky passed a comprehensive health education law in January 1979, and sex education "shall" be included. No further details are available as this is being written.

   Wisconsin calls it "health education" and stresses that each district decides for itself whether or not sex education is included in health education. South Carolina refers to "family living".

3. Maryland does not require state board approval, but does require that the board be notified of local plans.

   Tennessee does not require state board approval if sex education topics are covered in regularly scheduled courses in biology, home economics, or physical education. If a separate course is planned, however, the state board must approve it.

4. Colorado notes that, while parents must be allowed to request their child to be excused, parental permission is not required, i.e., children can excuse themselves.

   Maryland requires that parents can excuse their children upon written consent; all girls so excused are still legally required to receive instruction on menstruation.

5. Oregon suggests that separate sex education classes at the junior high level may be appropriate according to local needs.

6. Georgia and Minnesota recommend co-educational instruction, but explicitly recognize that there may be "exceptions". Texas only mentions that a separate course for "students interested in health professions" is available at the senior high level.

7. Washington makes no mention of classes for parents of school-age children, but does explicitly mention the importance of such classes for parents of pre-schoolers.

8. Maryland requires coverage of human reproduction, but "no earlier than age 10 nor later than 12".

9. Oregon suggests that venereal disease be covered, but discourages discussion of the "specific" methods of preventing it.

10. Maryland uses the term "male and female roles".

11. Minnesota states that birth control methods may be discussed, but not advocated.

12. Michigan legally prohibits discussing abortion as a method of birth control, but otherwise allows abortion to be covered.

13. Utah states that homosexuality may be discussed, but it must not be judged to be "normal" or "acceptable" behavior.

    In Maryland, homosexuality is a required topic since it is considered a "sexual deviation"; however, both grade level and mode of handling the topic may vary.

Periodic Evaluation

The second most commonly recommended program component is the periodic evaluation of classes or programs. As both educators and researchers, we are encouraged by this emphasis. Undoubtedly, this emphasis is a manifestation of the many conflicting claims made about sex education. Some people claim it increases sexual activity, while others claim it improves social relationships and reduces pregnancy. Although the best literature indicates that it does not increase any form of promiscuity, and may reduce unwanted pregnancies, the effects of a particular program can never be ascertained unless measured.

Unfortunately, four states, including two of those calling for periodic evaluation, explicitly restrict those methods of evaluation which can most effectively measure the success of programs. Specifically, Arizona, Louisiana, Utah, and Washington all discourage or prohibit educators from administering any tests or questionnaires about a student's personal sexual beliefs, attitudes, and behaviors. Rethinking some of these conflicting recommendations seems essential to improved program evaluation.

Unfortunately also, few schools have evaluated their programs, and those few evaluations tend to be based on small sample sizes, short time frames, invalid experimental designs, and unreliable and invalid instrumentation. To overcome these methodological deficiencies, states need to provide more than recommendations; they also need to provide methodological assistance and financial support.

Teacher Training

Over half the guidelines also recommend special training for the sex education teachers and staff. These recommendations seem most appropriate. The purpose of many sex education classes is not merely to fill the gaps in the knowledge of adolescents. Because many teenagers believe incorrect information and myths about sex, because they may be especially sensitive about their social relations in general and their sexuality in particular, and finally, because many teenagers have maladaptive attitudes and behaviors, teachers must be unusually knowledgeable, sensitive, and skillful. Appropriately, many teachers recognize their need for special training -- the most common reason for teachers' resistance to sex education is their concern over being insufficiently prepared (Clawar, 1977).

Horizontal and Vertical Integration

Two remaining characteristics of programs are recommended by a majority of the guidelines. These are vertical presentation of materials in several grades (i.e., material presented in grades K-12) and horizontal integration (i.e., materials presented in home economics, biology, health, etc.). There are several good reasons for presenting sex education material in different grades and classes. First, the young persons' sexuality and social relations are pervasive developmental processes and thus they should be covered at a

variety of times and from a variety of perspectives. Moreover, different types of material should be presented to different age groups. Second, if material is presented in more grades and classes, then more students will receive that material. On the other hand, vertical and horizontal integration does pose a major problem. It greatly increases the needed amount of teacher training and interdisciplinary coordination.

Separate Sex Education Classes

One program component, namely, separate sex education classes, is especially controversial. Six states recommend it and eight discourage it. Because it is most commonly separate sex education classes that provoke community debate, these guidelines reflect that controversy. Significantly, the survey of sex education professionals also indicates that professionals are divided over the issue of whether sex education should be taught in separate courses.

Topics for Discussion

Four topics were suggested or required by a majority of the guidelines: 1) anatomy and physiology, 2) human reproduction, 3) venereal disease, and 4) family roles and responsibilities. Decision-making skills and adolescent and adult values about sexuality are recommended by slightly less than half of the guidelines. None of the topics are discouraged or prohibited more than they are recommended or required. However, the most controversial topics, namely, masturbation, contraception, abortion, and homosexuality, are mentioned much less than most other topics. Thus, most states deal with these controversial topics by ignoring them or excluding them from guidelines. It is probably no coincidence that these four topics are also the topics least likely to be covered in the classroom (Hottois and Milner, 1975; Huether and Gustavus, 1977).

Supportiveness of the Guidelines

In order to assess the extent to which sex education guidelines support or hinder sex education instruction, the guidelines of each state were coded on the -3 to +3 scale presented below:

+3 legally required
+2 strongly encouraged
+1 weakly encouraged
0 neutral
-1 weakly discouraged
-2 strongly discouraged
-3 legally prohibited

The mean score for all forty states with guidelines is +.8, indicating that the guidelines weakly support sex education instruction. This mean is not higher because many states adopt a neutral position on many features of sex education instruction.

Means for each of the nation's regions were also calculated. They indicate that the South slightly discourages sex education, while the other regions, particularly the Midwest, slightly encourage it. However, after the score for Louisiana is removed from the mean score of the South, the South is only trivially different from the other regions. This is partly because a few southern states such as North Carol[illegible]a and South Carolina support sex education.

The National Institute of Education recently completed a survey of schools throughout the nation. The sample consisted of 1,448 schools. Ignoring the nonresponses of some schools, it represented a stratified random sample. From that data, we obtained the proportion of schools in each state that had separate sex education classes. Using the scale above, we then correlated the extent to which a state's guidelines supported or hindered sex education with the proportion of schools in that state having separate sex education classes. This correlation was based upon the twenty-six states which both 1) had guidelines and 2) had at least ten schools which responded to the NIE study. If the state had fewer than ten schools reporting then the sample size for that state was far too small to accurately estimate the true proportion of schools in that state having separate sex education classes. The correlation coefficient was .47. This indicates that, to a moderate extent, states which have supportive guidelines also have larger proportions of schools with separate sex education classes. For those eleven states which 1) specifically encourage or discourage specific classes in sex education and, 2) had at least ten schools responding to the NIE study we then correlated that recommendation in the guidelines with the proportion of schools in that state having special classes. As expected, this correlation was very high (R = .83). This indicates a strong relationship and suggests that the state guidelines have a considerable impact on the schools. Of course, the direction of causality cannot be determined from these data.

Conclusions

There are several conclusions that can be reached from this study. First, most, but not all, states have guidelines for sex education instruction, although some of the states replace the term "sex education" with "family life education" or some other term. Second, the guidelines vary greatly in their detail, their clarity, and their recommendations. Third, they strongly support local autonomy, the involvement of parents in the planning of programs, the public review of materials, periodic evaluations, special teacher training, and both the vertical and horizontal integration of sex education concepts and materials into different grades and courses. Fourth, some states encourage, while others discourage separate courses in sex education. Fifth, the guidelines tend to ignore controversial topics by neither recommending nor discouraging their inclusion in instruction. Sixth, the guidelines do not differ substantially by region. Finally, the supportiveness of a state's guidelines is related to the proportion of schools in that state having separate courses. This relationship is especially strong for those states explicitly recommending or discouraging separate courses. In

sum, the guidelines reflect the many debates about sex education throughout the nation and the lack of solid evidence about the actual effects of sex education programs. Most of the states could benefit from carefully evaluating the programs in their own states and from systematically analyzing the guidelines of other states.

APPENDIX

SUMMARY OF LAWS AND GUIDELINES FOR INSTRUCTION IN SEX EDUCATION IN THE STATE OF

There are laws or guidelines affecting sex education instruction in the State.

yes ☐ no ☐

If "no", the items below need not be completed.
If "yes", please indicate the particulars as follows:

Key

LR	Legally required by either the State's laws or the State's guidelines and having the full force of law.
S	Suggested or recommended by the guidelines or presented as part of a model curriculum.
D	Discouraged explicitly by the guidelines.
LP	Legally prohibited by the State's laws or guidelines.
(blank space)	Not mentioned by the law or guidelines.

	Jr. High School	Sr. High School
sex education instruction		
local autonomy over programs		
public review of program content		
involvement of parents and community in planning		
approval by district or local board		
approval by state board		
periodic evaluation of classes or programs		
advanced parent notification of student participation		
parental permission to attend		
parental permission to be absent		
horizontal integration of material into conventional classes (i.e. biology,		

health, home economics, etc.)	_____	_____
special classes focusing upon sex education	_____	_____
vertical presentation of material in several grades (e.g. material presented in grades K-12)	_____	_____
co-educational instruction	_____	_____
individual counseling	_____	_____
classes for the students' parents which complement the student classes	_____	_____
special training for the sex education teachers and staff	_____	_____
test questions on students' personal sexual beliefs, attitudes, and behavior	_____	_____
topics for discussion or activities		
Anatomy and Physiology	_____	_____
Human Reproduction	_____	_____
Contraception	_____	_____
Abortion	_____	_____
Venereal Disease	_____	_____
Masturbation	_____	_____
Homosexuality	_____	_____
Adolescent and Adult Attitudes and Values Regarding Sexuality	_____	_____
Family Roles and Responsibility	_____	_____
Sex Roles	_____	_____
Communication Skills	_____	_____
Decision Making and Problem Solving Skills	_____	_____

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*U.S. GOVERNMENT PRINTING OFFICE: 1980 - 646-895

2N7725879